

COMMUNITY CARE IN THE LONDON BOROUGH OF ISLINGTON  
FOR FORMER SHORT AND LONG-STAY PATIENTS  
FOLLOWING THE DECISION TO CLOSE FRIERN HOSPITAL

PhD

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### A B S T R A C T

This thesis describes a small-scale sociological study of the provision of community care in the London Borough of Islington for ex-patients following the decision to close Friern Hospital in Barnet, North London. Through semi-structured interviews with professionals and ex-patients, and observational studies, this qualitative research focussed on the experience of the recipients of care as a result of this major change in social policy.

There were numerous impediments to the smooth implementation of the closure programme. These included: negative attitudes of patients; differences between hospital and community environments; shortage of property; community opposition; lack of firm commitment to alternative employment for nursing staff; and, differences in philosophy on care within and between agencies involved. These problems were manifested in issues such as the selection of patients and medication policy, and were compounded by lack of regional directives and clearly defined areas of operation and responsibility. Commitment to more peripheral aspects such as case coordination and monitoring systems, and befriending schemes, locally, assumed greater importance as the study progressed.

There was no equality of care in the community for patients from the same hospital. There was lack of opportunity to undertake paid work (which exacerbated financial hardship) and engage in organised social activities in the community - both positive features of hospital life.



Community care in Islington for ex-long-stay patients meant living in residential projects in the community which did not necessarily meet their needs because these projects opened before patients' assessments were completed and little consideration was given to their opinions.

Nevertheless, and despite these short-comings, the general feeling about living in the community was positive and the majority had made good progress. Therefore, hospital closure benefited long-stay patients because otherwise many would have died there. However, their re-admission and the increased demand for admission during the closure programme showed that the District General Hospital would not be able to cope with the demand from all people suffering from mental health problems when Friern closed.

### A C K N O W L E D G E M E N T S

I should like to thank all the people who took part in this research - professionals from the statutory and voluntary sector involved with providing care in Islington, staff of Friern Hospital, and all the ex-Friern patients who so 'graphically' shared their experiences. Sincere thanks to all these people for their cooperation.

I should also like to thank the late Brian Grimley of the London College of Printing for his encouragement, Dr D Tomlinson from the Team for the Assessment of Psychiatric Services and Professors H Glennerster and M Bulmer at the London School of Economics & Political Science for their assistance at particular stages of the research. I should especially like to thank my supervisor Dr J Carrier also at the London School of Economics & Political Science for his guidance and support throughout.

This thesis is dedicated to the memory of George M Stewart.

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ABBREVIATIONS

ACO	Adult Care Officer
AEGIS	Aid for the Elderly in Government Institutions
CHC	Community Health Council
CMHRC	Community Mental Health Resource Centre
CMHRT	Community Mental Health Resource Team
COHSE	Confederation of Health Service Employees
CONCERN	Care of the Neglected: Combining Education, Rehabilitation and Nursing
CPN	Community Psychiatric Nurse
DGH	District General Hospital
DHA	District Health Authority
DHSS	Department of Health & Social Security
DLP	Daily Living Programme
DOE	Department of Environment
DSS	Department of Social Security
DV	Dependent Variable
ECT	Electro-Convulsive Therapy
EN	Enrolled Nurse
ENB	English National Board
GP	General Practitioner
HA	Health Authority
HM	House Manager
HSW	Housing Support Worker
IHA	Islington Health Authority
IMHF	Islington Mental Health Forum
IV	Independent Variable
LBI	London Borough of Islington
LCC	London County Council



MCC	Middlesex County Council
MoA	Memorandum of Agreement
MP	Member of Parliament
MTHS	Months
NETRHA	North East Thames Regional Health Authority
NHS	National Health Service
NO	Neighbourhood Office
OP	Operational Policy
OT	Occupational Therapy
PBT	Peter Bedford Trust
PRA	Psychiatric Rehabilitation Association
PRG	Progress Review Group
PSE	Present State Examination
PSU	Priority Services Unit
RCN	Royal College of Nursing
RMN	Registered Mental Nurse
RSM	Residential Services Manager
RTF	Rehabilitation Task Force
SSD	Social Services Department
SWT	Social Work Team
TAPS	Team for the Assessment of Psychiatric Services
TT	Transitional Team
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation
YRS	Years

## C H A P T E R 1

### INTRODUCTION

#### BACKGROUND TO THE RESEARCH

Since the mid 1960's, policy discussions and debates have taken place about the appropriateness of mentally ill people continuing to be cared for in 'asylums' with a view to reproviding care in more community-based settings. In July 1983, North East Thames Regional Health Authority (NETRHA) announced a policy of closing its two main psychiatric hospitals - Friern in North London, and Claybury in Essex. The closures were planned to take place over a ten year period and were based upon a policy of each Health District reproviding psychiatric services in the community (Tomlinson, 1991)<sup>1</sup>.

#### PERSONAL IMPETUS FOR THE RESEARCH

In 1987, the researcher witnessed the negative attitudes displayed by members of a Housing Cooperative operating in the London Borough of Islington (LBI) to two fellow members who had been short-stay patients in Friern Hospital. This led the researcher to question how Islington residents were reacting to long-stay patients of Friern Hospital being discharged into their community as a result of hospital closure, and also what was the experience of these long-stay patients of community care in Islington.

#### THE FOCUS OF THE RESEARCH

NETRHA began monitoring the progress of its policy when the hospital closures were announced, and commissioned the Team for the Assessment of Psychiatric Services (TAPS) to carry

out major research into the clinical, administrative, and economic aspects of reprovision with an emphasis on the collection of objective data (Goldie, 1988, p5)<sup>2</sup>. Thus, there was an opportunity for a small-scale sociological study which focussed on the experience of the recipients of the policy which would mean adopting a more interpretative approach. Given this opportunity and the personal impetus for the study, the researcher decided to limit the research to one hospital - Friern, one community - Islington, and one group of patients - the long-stay patients on the Islington wards of Friern, although some other ex-Friern patients were eventually included.

#### THE RESEARCH 'UNIVERSE'

##### Friern Hospital

Friern Hospital in Friern Barnet, in the North (Outer) London Borough of Barnet was situated in an area of mixed land use (residential and commercial) on a busy bus route, next to a British Rail Station (New Southgate) and only ten minutes walk from a London Underground Station (Arnos Grove). There was a tolerant surrounding population because all the residential areas in the vicinity had grown up around Friern Hospital (NETRHA, 1990, p12)<sup>3</sup>.

When Friern Hospital had opened on 17th July 1851 as Colney Hatch Pauper Lunatic Asylum, it was hailed as Europe's largest and most modern institution, and was much visited by those attending the Great Exhibition (Hunter & McAlpine, 1974)<sup>4</sup>. When Friern Hospital finally closed on 31st March 1993, and work began on clearing the site, the

hospital's listed frontage remained as a testimony to the fact that it had begun life in the asylum age of psychiatry.

Friern's role had always been that of a service of last resort. There was a large percentage of people suffering from schizophrenia on its acute and long-stay wards TAPS (1988)<sup>5</sup>. Friern also accommodated elderly people with severe dementia who had been rejected by other services, and offenders and people with extremely challenging behaviour in its Medium Secure Unit, for which there was a waiting list (NETRHA, 1990, p1-2)<sup>3</sup>.

The Health Districts served by Friern were Hampstead, Bloomsbury, Islington, and Haringey which were within the North (Inner) London Boroughs of Camden, Islington, and Haringey, respectively. An outline and map showing the London Boroughs appear in *Appendices 1.1* and *1.2*, respectively.

The boroughs of Islington and Haringey had coterminosity with their District Health Authority, whereas Camden had two Districts (Hampstead in the north and Bloomsbury in the south), until the merger of Bloomsbury and Islington Health Authorities in August 1990. Hampstead Health Authority had been the managing District of Friern Hospital since 1982 when, with National Health Service (NHS) reorganisation, it took over from Islington. By this time, Friern's annual budget was about £13m - 20% of the total health services spending of its managing district. (UCL 1987, p1)<sup>6</sup>

Medical and nursing staff at Friern were employed on a District Health Authority (DHA) basis. Friern was the sole

provider of hospital services for Haringey but the other three Districts had additional beds and Day Hospitals within their district boundaries - Bloomsbury at University College and St Luke's, and Hampstead and Islington at the Whittington and Royal Free Hospital Psychiatric Units, respectively. However, Islington relied on Friern for all services for the elderly severely mentally ill whereas Bloomsbury and Hampstead had some local provision. Each of the Districts had its own acute and long-stay wards, and a Day Hospital at Friern. They could also use the Psychotherapeutic Day Hospital in Halliwick House, two wards for intensive rehabilitation, and the Interim Medium Secure Unit. (NETRHA, 1992, p9 paras 30 & 31)<sup>7</sup>

Social services were provided by social workers from each of the boroughs serving Friern. The many varieties of occupational, industrial, and recreational facilities, and para-medical support services were provided on a non-divisional basis. (UCL, 1987, p2)<sup>6</sup> The huge size of the long-stay population (c. 850 at the time of the closure announcement) made it possible to offer a wide variety of facilities: occupational and industrial therapy; special units for music, art, and pottery, psychotherapy, and social skills; the provision of different diets and religious services; patients' clubs and a cafeteria; a gymnasium with remedial gymnast; hairdressers and a boutique; and specialist services such as dentistry and physiotherapy. These amenities were provided in extensive and attractive grounds and constituted, despite the connotation of 'the total institution' an ongoing community (Weller, 1985)<sup>8</sup>. A

map of the building and grounds of Friern Hospital when the closure announcement was made is contained in *Appendix 1.3*.

### The London Borough of Islington

The LBI is an Inner-London borough in the north of the capital with a resident population of approximately 160,000. It has a predominantly Labour Council, and both North and South Islington have returned Labour Members of Parliament (MP) at the last three General Elections although in the wealthier south, this was only with a very small majority in the 1987 Election. A more comprehensive picture of the LBI can be gained from looking at key statistics from the Census Data for 1981 and 1991 shown in *Appendix 1.4*.

The LBI had coterminousity with its Health District, until the merger with Bloomsbury in 1990, and had five Health Locality Areas as shown on the Islington Council Street Map (1988) in *Appendix 1.5*. According to the Jarman Index (1983, 1984)<sup>9</sup>, which combined eight census variables to give a single score of social deprivation for each Health District, Islington had a District Jarman Score of 38.7 which was well above the average national deprivation index score (0). It had the highest score of the Districts served by Friern Hospital, although all four were among the 22 most underprivileged Districts out of a total of 192 Health Authorities.

LBI Social Services Department (SSD) began a major reorganisation in 1982. The principles of the reorganisation were to integrate day, residential, and field services, and to decentralise these services, in line with

council policy, to Neighbourhood Areas. There are 24 Neighbourhood Areas and Offices in the borough, as shown on the Islington Council Street Map (1988) in *Appendix 1.6*. Area Teams, providing duty and specialist social work and emergency services, are based at Neighbourhood Offices (NO) and, as far as possible, decisions are made at the local level. The NOs deal, not only with Social Services, but also with Environmental Health, Housing, Community Charge (and formerly Poll Tax) Benefits, Council Property Management, Lettings, and Rent on a local basis.

#### Long-Stay Patients

The four Health Districts served by Friern were together responsible for just under 450,000 people (Margolius, 1988, p1)<sup>10</sup> although, due to changes in administration and catchment areas over the years, about one sixth of the long-stay patients had originated in other Districts. For the purposes of reprovizion, however, they were all the responsibility of one of the four health Districts and were divided into two groups:

Psychogeriatrics - elderly people suffering from dementia;

Non-psychogeriatrics - adult mentally ill people who had been in hospital for more than one year, or had a history of multiple admissions.

The TAPS Preliminary Report on Baseline Data (1988)<sup>5</sup> was a rich source of data on this second group, and a summary of this can be found in *Appendix 1.7*. It can be seen from this data that 80% of non-psychogeriatrics had been diagnosed as suffering from schizophrenia, and TAPS

reported that there was no significant difference between patients in the four Health Districts with regard to illness. It can also be seen that c. 20% of non-psychogeriatrics were from minority ethnic groups. No demographic data was published for psychogeriatrics because this group of patients was ever-changing due to their high death rate and the equally high demand for places.

When the decision to close Friern Hospital was announced, there were 280 long-stay patients on the Islington wards (100 psychogeriatrics and 180 non-psychogeriatrics). This was the number to be provided for in the community because, although it was known that some people in this initial group would die before they could be moved out of the hospital, it was also anticipated that they would be 'replaced' by people who would become 'long-stay' in the ten year period allocated to execute the closure programme.

#### THE LITERATURE REVIEW AND STUDY OF POLICY DOCUMENTS

In order to place the research in context and to help define the research questions and methodology, the researcher studied the policy documents of NETRHA and Islington Health Authority (IHA) on hospital closure and care in the community and reviewed literature in the following areas: the philosophical foundations of research methods; methods used in the mental health field and the findings of studies which appeared to have particular relevance to this research; the condition known as schizophrenia; the history



of the mental health services in England and Wales; and, the history of Friern Hospital.

### THE RESEARCH QUESTIONS

Following the literature review and study of policy documents, the researcher discussed the following issues with the research supervisor and a member of TAPS: reasons for Friern closure; definitions of community care; the planned closure programme; public consultation exercises; the assessment of patients; and, patients' choice. Finally the aims of the research were defined by the following research questions.

1. To find out if all the long-stay patients on the Islington wards would be provided for in the community by the closure date. If they were, the closure programme would be evaluated in terms of the smoothness of its implementation and the adequacy of community provision. If they were not, evaluation would centre on any constraints to implementation as well as the consequences for long-stay patients.
2. To find out what 'community care' in Islington meant to ex-long-stay patients by assessing how the different agencies involved in the closure programme had interpreted this policy, and how it was experienced by ex-patients.
3. To determine how far planned reprovision had been based on an assessment of patients' needs and to what extent patients had chosen their own placements in Islington.

4. To consider if the nature and attitude of the host community was an important consideration in the implementation of the policy of community care for ex-Friern patients in Islington.

Research which has attempted to evaluate the implementation of the policy of hospital closure and care in the community has, hitherto, generally concentrated on the views and experience of professionals involved in its planning and implementation. In this tradition, the answers to the above questions from the professional perspective would be essential in evaluating Islington's hospital closure programme and community care in Islington. However, the researcher had introduced measures which would also allow interpretation of this major change in social policy through the eyes of the clients and the community.

Thus, the researcher hoped that this small-scale study would go some way to redressing the present imbalance and, consequently, look at the implementation of this policy from both an in-depth, by virtue of its qualitative nature, and wider perspective through the inclusion of two groups who have previously not been a high priority in research of this nature - the clients and the community.

#### OUTLINE OF THE THESIS

##### Abbreviations and References

As in this Chapter, names and titles to be abbreviated appear once in full with their abbreviations in bold and in brackets. Thereafter, they appear in abbreviated form as shown in the alphabetical list of abbreviations.

When authors are first cited in a chapter, their names appear in bold. References for each Chapter appear at the end of each Chapter.

### Chapters in the Thesis

Chapters 2, 3 and 4 are concerned with Methodological Issues. Chapter 2 discusses the philosophical foundations of research methods and Chapter 3 focuses on methods used in the mental health field and findings of studies which are of particular relevance to this research, that is, the experience of ex-long-stay patients in the community and the attitude of the community to them. Chapter 4 discusses the methods which were used in this study to answer the research questions, the problems that were encountered and what eventually was achieved.

Given the large number of people suffering from schizophrenia in Friern Hospital, this condition is the subject of Chapter 5. Since this study is concerned with a major policy change in the care of mentally ill people, Chapter 6 discusses important themes in the history of the mental health services in England & Wales. Chapter 7 acts as a bridge between the Literature Review and the Findings of this study by looking at the history of Friern Hospital before the closure programme, the rationale on which the decision to close was based, and the effect of the closure announcement on the hospital.

Chapter 8 presents the findings of the research with regard to the experience of professionals involved in Islington's closure programme, the projects for ex-long-stay

patients in the community, procedures for moving them from the hospital to the community, and important events in the closure programme.

Chapter 9 discusses the findings of the Pilot Study, that is, the experience of ex-long-stay patients who were part of Hampstead Health Authority's closure programme.

Chapter 10 presents the findings of the research with regard to how ten long-stay patients in Islington's closure programme who were living in one of the first five residential projects in Islington had personally experienced the move to the community. Their accounts are supplemented with the perceptions of their 'carers'.

Chapter 11 is concerned with the experience of another eight ex-patients of Friern Hospital, attending a Day Centre in Islington, who were not part of Islington's closure programme because they were discharged before it began or were short-stay while it was in progress.

Chapter 12 summarises the final conclusions and recommendations of this study.

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## C H A P T E R 2

### THE PHILOSOPHICAL FOUNDATIONS OF RESEARCH METHODS

#### INTRODUCTION

In Chapter 1, this study is described as a small-scale qualitative study of a major change in social policy, and the research questions reflect the importance attached to how mentally ill people have experienced this change.

A researcher's choice of research methods may be influenced by many extrinsic factors: the topic or characteristics of the people being investigated; the time available to carry out the study; and the resources, both human and financial, available. It is primarily dictated, however, by an intrinsic factor - the researcher's view or the view of those commissioning the research, of social reality.

A sociological theory is a set of ideas which provides an explanation for human society. By adopting a theoretical position, the researcher is making a statement about his or her view of social reality. The adoption of a theoretical position is important not only because of its influence on the choice of topic for investigation but because it also determines the research questions, predictions about the outcome, and whether or not to construct and test an hypothesis. This ultimately dictates the type of data to be collected, the source of the data, the methods used to collect the data, and how the data is to be interpreted and presented.

In sociology there are at least two radically different and conflicting views of social reality - Positivism and Phenomenology.

The Positivist view of social reality sees societies as wholes or as systems of interacting parts, which have properties which cannot be deduced from the characteristics or behaviour of individuals. Those who adopt a positivist approach are concerned to show how society affects individual and group behaviour and seek scientific explanations of social reality.

In contrast, the Phenomenological view of social reality focuses on the actions and interactions of individuals and groups who create, find meaning in, and experience society rather than on how society affects them. Proponents of this perspective seek to discover the meanings which direct actions in order to understand these actions.

Further insight into this debate can be gained by first considering the work of the 'founding fathers' of Sociology - the 'Positivists', August Comte and Emile Durkheim, and Max Weber who was both a supporter of Positivism and the champion of Phenomenology.

#### AUGUSTE COMTE AND EMILE DURKHEIM

August Comte (1798-1857) first applied the term 'Positivism' to sociology to illustrate his conviction that the methods which had proved so successful in the physical sciences would be appropriate for the study of social phenomena. Thus, his 'philosophie positive' as sociology was called was to concern itself with facts, observable entities known

directly to experience. Its aim was to construct general laws which would express relationships between social phenomena and by the use of observation, experimentation and comparison, a particular phenomenon might be tested for compliance with the original hypothesis.

Since science was an area from which value judgements were excluded, Comte's positivist sociology would neither admire nor condemn social facts but look on them as 'objects of observation'. He was committed to value-neutrality as a general characteristic of the scientific method and believed that its application to the study of society could bring individuals happiness through social control. (Thompson, 1976)<sup>1</sup>

Many of the criticisms of Comte's conception of the scientific method centre on the characteristics he attributed to scientific knowledge. In the empiricist tradition, he believed that this must be based on sensory observation. Marcuse (1985)<sup>2</sup> said of him:

*"He shackles thought to immediate experience but at the same time widening the realm of experiences so it ceases to be restricted to the realm of scientific observation but claims also various types of supra-sensual power." (p343)*

Further, in limiting the object of scientific knowledge to phenomena which were directly observable, Comte restricted the scope of human knowledge.

Marcuse was also critical of Comte's claim to value-neutrality. He argued that since positivism does not allow criticism of the existing social order, it is politically conservative and thus, not neutral. Consequently, positivist sociology is 'apologetic and justificatory'



rather than being value-free. It tends to look for observational or experimental support for general laws at the expense of critical analysis of the concepts in which the laws are expressed.

Empiricists were disappointed with Comte's failure to apply the scientific method to sociology but the same cannot be said of Emile Durkheim (1858-1917). Durkheim also wanted sociology to be a 'science of society' so that it could command the same respect as the natural sciences, and he also believed that the methods of the natural sciences were applicable to the study of society. For 'biological facts' he substituted 'social facts' which he defined as 'ways of thinking or feeling, reflected in the way people behaved'. These social facts were phenomena which could be objectively studied so that 'real laws would be discoverable'. For Durkheim, society existed as an external reality and individuals were constrained by social facts. (Giddens, 1972)<sup>3</sup>

Durkheim's work, *Le Suicide* (1897)<sup>4</sup>, with its emphasis upon the discovery of objective social facts through the statistical analysis of quantitative data has become established as a classic positivist study. Although suicide is the most individual of acts, Durkheim was adamant that it should not be studied by looking at individual motives.

*"We shall try to determine the productive causes of suicide directly without concerning ourselves with the forms they assume in particular individuals. Disregarding the individual as such, his motives and his ideas, we shall seek directly the states of the various social environments in terms of which variations of suicide occur."* (p27)

Durkheim began his study with a detailed analysis of official statistics on suicide from a number of European countries but did not study a single suicide himself. He found that each country's suicide rate was fairly consistent over a period of years and that patterns were emerging which indicated differences in the suicide rate between social groups in each country. His hypothesis was that suicide varies inversely with the degree of integration of the social groups of which the individual forms a part.

He used the method of concomitant variation to test his hypothesis. This is a quasi-experimental method which permits the use of quantification and precise comparisons. He tried to produce causal laws by isolating and comparing variables from some 26,000 cases. He first compared a countable phenomenon (suicide rate) with other measurable phenomena, for example, marital status and religion. He then elaborated his analysis by comparing variables with which the suicide rate had varied consistently and produced correlations which showed the causal link between suicide rate and group ties, outlined in his hypothesis.

Most of the criticisms of Durkheim's work have focussed on his use of official statistics. The rates of suicide for countries were produced from vastly different totals and the procedures for investigating and recording unnatural deaths at the time varied from country to country and between rural and urban areas. Nevertheless, Durkheim's study of suicide was, especially for the time it was conducted, an outstanding example of how the scientific approach can be used to study society. It has also served as a reference point

for those who reject the traditional positivists' view of social reality and the methods they adopt to understand this reality.

Interactionists such as Douglas (1967)<sup>5</sup> and Atkinson (1971)<sup>6</sup> criticised Durkheim for basing all his evidence on official statistics and ignoring the 'fact' that the individual has a 'self' and an individual consciousness. They reject the view of man totally controlled and moulded by social forces and argue that by treating official statistics on suicide as having objective reality is to misunderstand their nature. They are the meanings actors attach to events which they have perceived and interpreted as suicide, and these events have no existence outside the interpretive procedures which created them. Suicide statistics are socially created and there is no 'real' suicide rate waiting to be discovered - the process of measurement produces the rate.

Douglas described how the amount of integration can itself determine whether or not death is regarded as suicide eg. people living alone have no family to 'negotiate' the cause of death, whereas the Catholic community may try to disguise a suicide to save the family from shame and the deceased from eternal damnation. Atkinson suggested that the most important question to be asked is "How do deaths get categorised as suicide?" His own research focussed on the methods used by coroners to categorise death. When a person dies in ambiguous circumstances, they examine the life of the deceased to see

if the suicide is understandable, look for clues which suggest suicide, and reach their verdict using common-sense notions of what prompts suicide.

The importance attached to the understanding of human action by Douglas and Atkinson can be traced back to the work of Max Weber (1864-1920).

### MAX WEBER

Weber (1922)<sup>7</sup> defined sociology as "...*a science concerning itself with the interpretive understanding of social action and thereby with a causal explanation of its course and consequences*" (vol 1, p4). This shows that he was committed to scientific sociology but it also made him the innovator of interpretive sociology. He started from the fundamental neo-Kantian division of the natural and social sciences but argued that objective knowledge is possible in the social sciences, that the knower is not condemned to be purely subjective and evaluative because the object of his knowledge is the realm of values.

For Weber, 'social action' was the object of sociological knowledge. He distinguished between: action which was meaningful social behaviour and purely reactive behaviour which was non-meaningful as far as interpretive sociology was concerned; individual social actions, its meanings and causes, and supra-individual social entities such as states, institutions and classes. These entities were 'social facts' in that their existence could not be denied and although they played a part in the situation of

individuals and therefore in their actions, Weber argued that, in interpretive sociology, they must be treated solely as 'resultants', modes of organising the particular acts of individuals.

Weber viewed human beings as active, purposive free agents thus allowing for elements of unpredictability and individuality which could not be subject to natural laws and understood using the analytical and generalising methods of the natural sciences. He offered the category of the 'ideal type' as a methodological tool, a guide in the construction of hypotheses and a mental construct to help illuminate reality. By helping to explain the nature and causes of action and understand the particular by relating it to the general, it was the counterpart of the experimental method in the natural sciences. According to Outhwaite (1975)<sup>8</sup>, for Max Weber,

*"sociology is a generalizing science in the sense that, unlike history, it looks for general regularities in what takes place; its theories do not so much consist of lawlike statements as make provisional and conditional use of them. Sociology is a consumer rather than a producer of laws. In addition, of course, these regularities must be 'understandable' if they are to provide an adequate explanation. They must be 'meaningfully adequate' as well as 'causally adequate' in the sense of the empirically well-supported." (p163)*

An example of this is found in Weber's study entitled *The Protestant Ethic and the Spirit of Capitalism* (1906). Using the comparative method of difference, he suggested that a suitable set of strong motivational values (Protestant Ethic) is one of the many contributory causes of Capitalistic development. This method is qualitative since it merely tries to ascertain the presence or absence of

phenomena in an attempt to argue about their causal significance and does not have to measure and compare how much of a variable is present.

Weber believed his explanation was causally adequate because he had compared a number of societies and civilisations eg. Western Europe, China, India, Islam, over wide periods of history and shown that the link between certain types of Protestantism (Calvinism) and Capitalism was not accidental, but objectively possible. Moreover, it was meaningfully adequate because he had shown how the typical believer views the world, what values and ideals he utilises to make work, in general, and his own actions, in particular, intelligible and justifiable.

For Weber, the subject matter and methods of any research would be 'value-laden' since researchers choose to study factors which they feel to be important. This choice is a reflection of their own theoretical problems which are partly a function of their own values.

Weber did not believe that value-judgements could, or should, ever be removed from the sphere of social science research although social scientists should be clear about and confront their own values and ideals, and their relevance to the work, and strive for objectivity within these assumptions. They would never be able to predict with certainty the final choice of the human actor but by understanding and explaining the meaning of social action and interaction they should be able to point out the advantages of choosing one means over another to achieve a desired end. Weber did, however, favour the empirical

approach and felt that objectivity could be obtained and total subjectivity avoided by defining limits into which ideals may not intrude in scientific analysis. Thus, he was both a supporter of Positivism and a champion of Phenomenology.

The word phenomenology is derived from the Greek 'phainemenon' meaning 'that which appears' and comes from a tradition of thought associated with Edmund Husserl (1859-1938). Husserl advocated the suspension of all metaphysical and epistemological presuppositions to identify and describe the essences of experience as they were intuitively apprehended in the 'life-world' which he defined as the given world, the practical world and the social world. For Husserl then, experiences were the subject matter of phenomenology, and a study of them could help to clarify the foundations of knowledge. (Picevic, 1976)<sup>9</sup>

The sociology of knowledge is a central concern in Phenomenology. In their sociological analysis of everyday life, as experienced by individuals Berger & Luckman (1969)<sup>10</sup> describe how knowledge can range from the limited common-sense variety to that of the expert but it is not whether it is true or false that is important but what is thought of as knowledge since social phenomena evoke reactions in terms of one's own common-sense knowledge. They also emphasise the importance of both objectivity and subjectivity, for example, the meanings given to actions are as important as the actions themselves since they cannot be understood unless their meaning is understood.

Phenomenology also stresses the importance of language, not in terms of its technical aspects but in its broader meaning contexts, since a society's meanings are stored in its language. Similarly with other aspects of expression and communication. For phenomenology, however, the basic subject matter of sociology is the experience of the life-world and it is the importance that phenomenologists attach to taken-for-granted assumptions that divide them from other sociologists, for example, those who say "let's go and study yuppies", assuming there is agreement on what 'yuppies' are.

In sociology, Phenomenology has come to refer to the study of social phenomena from perspectives which are loosely termed Interpretive - Symbolic Interactionism and Ethnomethodology.

### SYMBOLIC INTERACTIONISM

Following Weber, Symbolic Interactionism emphasises the actor's views and interpretations of social reality and adopts an 'action' approach. George Herbert Mead (1863-1931) formulated the main ideas of Symbolic Interactionism, and shared with Weber the idea that it is the social scientist's task to understand the purpose and meaning of social action.

For Mead (1934)<sup>11</sup>, human thought, experience and conduct are essentially social since humans interact in terms of symbols, for example, language. These symbols are man-made and largely shared. They define objects in a particular way, impose meanings and provide a way for man to



interact meaningfully with, and respond to, the natural and social environment. These symbols are necessary because man, as distinct from the subjects of the natural sciences, is not genetically programmed to react automatically to stimuli. For interaction to take place, each person must interpret the meanings and intentions of others. This is accomplished by role-taking, and through this the individual develops a concept of 'self'. Thus, man actively creates his social environment and is shaped by it. The individual and society are inseparable because the individual can only become a human being in a social context.

Following Mead, Blumer (1969)<sup>12</sup> described Symbolic Interactionism as resting on three basic premises: human beings act on the basis of meanings they give to objects, they do not react to external stimuli (social forces) or internal stimuli (organic drive); meanings arise from the process of interaction, they are not present at the outset; and meanings are the result of interpretive processes employed by actors in the context of interaction.

This view of society as an ongoing process of social interaction, involving actors who are constantly adjusting to one another and interpreting the situation, is in contrast to that of positivism. Blumer did accept that action is, to some degree, structured and routinised but also believed that there is always room for manoeuvring and negotiation. He recognised the constraints of institutions but he believed that there was still room for human initiative and creativity. Consequently, he rejected the idea of isolating individuals and establishing causal

relationships. He advocated that social researchers immerse themselves in the areas of life they want to investigate and describe the circumstances, without making external judgements.

Interactionists are critical of those who impersonate the natural scientist and they, in turn, are criticised for their indifference to the problems of evidence, proof, and systematic theory, since to understand, you have to put yourself in somebody else's place which involves emotional speculation which, because it cannot be checked or verified, is unscientific. Interactionists also criticise the deterministic view of the relationship between the individual and society and, in turn, are criticised for their inattention to the importance of structural constraints. By examining human interaction in a vacuum eg. in small-scale studies, and face-to-face situations, they show little concern for the social structure which generates the meanings to which they attach such importance. However, small-scale studies need not exist in a vacuum if, as in the case of this research, they are a 'typical' example of the effect of a national policy.

Interactionism mainly developed in America via studies of crime and deviance. Becker (1963)<sup>13</sup> and Lemert (1972)<sup>14</sup> argued that social scientists must see the view and understand the experience of the deviant or criminal as well as the authorities who labelled him or her. It is not their role to decide who is right or wrong but to describe how decisions are made and how these affect people.

With the emphasis that American society places on liberty, freedom, and individuality, it is understandable that this phenomenological approach has found greater support in America than in Europe, where there has traditionally been a greater awareness of the constraints of power and class domination, and a history of adherence to the positivist approach. This also explains why Ethnomethodology has developed largely in America.

### ETHNOMETHODOLOGY

The term Ethnomethodology was coined by the American Harold Garfinkel. Using concepts such as 'member' which is the Interactionists' actor, 'indexicality' which refers to making sense of any event by relating it back to its context, and 'reflexivity' which refers to the inter-relatedness of meaning and event, Garfinkel (1976)<sup>15</sup> attempted to demonstrate the seen but unnoticed order of everyday life.

Garfinkel, in particular, and ethnomethodologists in general have acknowledged the importance of the ideas of Alfred Schutz (1899-1959) who confronted the philosophy of Husserl with Max Weber's sociology of action and understanding. For Schutz (1932)<sup>16</sup>, all direct experiences of humans are experiences in and of their 'life-world' which, diverging from Husserl, is the same as the 'social-world'. This 'life-world' is prestructured for the individual but, in contrast to Durkheim, he emphasised the subjective meaning of a person's membership in the community, and how ideas only exist in the minds of

individuals who absorb and interpret them on the basis of their own life situation. Schutz describes how people can only make themselves intelligible to one another by taking established 'roles' and how it is the common-sense knowledge possessed by all socialised human beings which organises the social world.

According to Schutz, both Husserl and Weber had failed to bring out the intersubjective nature of the social world, that is, how subjective understandings formed by isolated individuals mesh together in the orderly social world. He also noted that an understanding of the social world is not unique for each individual, there is reciprocity.

Wagner (1975)<sup>17</sup> describes how for Schutz, Weber's notion of the ideal-type was too structured. He offered two typifications - that of the action and that of the agent which have two ways of understanding and of being understood, and he noted the link between typification and relevance in that people would be unable to recognize what is relevant were it not for their acquaintance with the socially approved system of typifications. Schutz also distinguished between 'in order to' motives which are essentially subjective and 'because of' motives which are essentially objective, and between 'conscious' and 'unconscious' behaviour.

In *The Stranger* (1944), Schutz attempted to show how social life does not exist apart from the consciousness of men living that life. He discusses the individual's knowledge of the social - how it varies, is incomplete and

partial but has sufficient coherence, clarity and consistency for people to have a reasonable chance of understanding each other. Schutz's outline of observation and participation in the life-world eg. in how the stranger's detachment allows him to offer an objective view of the host community is an important consideration in social research. He advocated that sociologists attempt to grasp the multiple realities of the social world rather than being totally concerned with precision and accuracy which have no relevance for actors in their everyday lives. Their first concern must be how actors understand social actions.

Using the ideas of Garfinkel and Schutz, ethnomethodologists seek to find out how individuals make sense of their social experience by looking beneath the surface at the nature and structure of common-sense reasoning in everyday life. They examine the methods and procedures employed by members of society to construct, account for, and give meaning to their social world, and consequently impose order on information and situations when no objective order exists. For example, Cicourel (1976)<sup>18</sup> argues that juvenile delinquency, which is usually regarded as a social fact, should not be divorced from the methods by which it is identified and advocates describing the methods of practical reasoning and decision-making by which the label and the occasion are mutually constituted.

Ethnomethodologists believe that generalisations in social research are dangerous and warn that researchers, too, have common-sense values and beliefs which may influence their work. They prefer small-scale, detailed,

and specific studies to those on a national level. However, it is possible to generalise from small-scale studies on the effect of a national phenomenon, as in the case of this research.

A major criticism of the work of many ethnomethodologists is that they begin with the assumption that society exists only in so far as members perceive its existence. They do not consider that it may be the nature of power or the effect of structural constraints that make people behave in a particular way. They often seem to lack any motives or goals and their process of accounting for accounts can seem never-ending. Consequently, their work is often trivialised for being no more than a study of microscopic social processes. Ethnomethodologists, however, often ask interesting questions about areas of life which are often neglected by more 'traditional' researchers, and they do this in the search for knowledge.

#### POSITIVISM V. PHENOMENOLOGY - THE DEBATE SUMMARISED

The following characteristics are generally attributed to Positivism in sociology: (i) the 'scientific method' which is used to study the natural world is also applicable to the study of the social world; (ii) the goal of inquiry is to study behaviour which produces measurable data, ie. objective facts, from which it will be possible to formulate laws, make generalisations, and offer predictions along the lines evident in the natural sciences; and,

(iii) sociological inquiry is independent of the social world being investigated and facts and values are distinguishable for the purposes of scientific analysis.

Phenomenology rejects this approach on the grounds that: (i) the subject matter of the social and natural sciences is fundamentally different - man has thoughts and feelings, he does not merely react to external stimuli, but actively constructs his own social reality, so it is inappropriate to use the same methods to study them; (ii) the behaviour of man cannot be objectively measured to produce statements of cause and effect because his actions are meaningful and the subjective meaning must be discovered to understand the action; and, (iii) sociological inquiry is part of the social world being investigated so the common-sense assumptions made by researchers must also be understood.

These conflicting views of social reality are expressed in the type of data, the methods used for gathering data, and the level of analysis, favoured by their proponents. Positivists tend to favour quantitative methods, objective data and analysis at the macro level, whereas phenomenologists prefer qualitative methods, subjective data and analysis at the micro level. However, just as there was fusion of the positivist and phenomenological perspective in the work of Max Weber, so these distinctions are not always as clear-cut as they first may appear.

### TYPES OF DATA

The terms generally used to describe the types of data used or collected by social researchers are: primary and secondary; quantitative and qualitative; and, objective and subjective.

Primary data is data collected by researchers themselves whereas secondary data is collected by others. There is a wealth of secondary data available to social researchers, for example, official statistics, historical documents and records, and the findings of previous studies.

Official Statistics are compiled by Government Agencies. They are large-scale, if not universal, sources of detailed information which is both authoritative and respected. They are, however, often produced for specific purposes and consequently may be limited with regard to a researcher's particular area of interest and classified under headings which cut across important sociological concepts. Official statistics should, therefore, always be clearly defined because of their importance for, and influence on, social policy.

Official statistics, like other sources of secondary data, can provide a general background for a range of studies and form the basis for comparison and generalisation. When using or referring to these, however, the researcher must always be aware of when the data was collected, from what source, by whom, for what purpose, and in what way.

As previously discussed, positivists treat official



statistics as 'facts', whereas phenomenologists regard them as constructions of meaning. This also applies to other statistics, that is, those compiled from 'primary data'.

Statistics are a convenient way of presenting information but no matter how 'scientific' they appear, the process of collecting information is still social. Thus, the researcher must always ask what lies behind them, and be alert to the existence of 'shadow figures', the statistics behind the published version. Nevertheless, statistics are usually considered to be 'objective' or 'quantitative' data or the products of this type of data, whereas narratives and case studies are regarded as 'subjective' or 'qualitative' data, or its derivatives.

The terms 'quantitative' and 'objective' are generally used to denote true, scientific, rigorous and real, and 'qualitative' and 'subjective', in contrast, are used to denote arbitrary, biased, unscientific and personal opinion. These terms are, therefore, used evaluatively to describe the method of investigation which produced these types of data and are also associated with a particular level of analysis.

## RESEARCH METHODS

As outlined above, the objective mode of inquiry has been considered to be the scientific way to proceed in social science research and the subjective is associated with a phenomenological approach. It should be noted, however, that phenomenology does not divide the subject from the

object of the study - the objective and objectivity are subjective or intersubjective constructions.

Nevertheless, positivists tend to advocate the use of quantitative methods for the purpose of theory-testing, and phenomenologists favour qualitative methods for use in theory-construction. A summary of research methods appears in *Appendix 2.1*.

The experimental situation is much acclaimed by positivists because it is the most effective method of testing an hypothesis of causal significance, that is, that a particular characteristic or occurrence, the independent variable (IV) is one of the factors that determines another characteristic or occurrence, the dependent variable (DV).

For positivists, the structured questionnaire is the main tool for gathering data in a social survey since it allows the scientific measurement of social phenomena. Phenomenologists reject questionnaires which have operational definitions because they distort the social reality they are seeking to understand. They do not regard the social survey as a precision instrument since survey design is an art as well as a science, and no more so than in the compilation of questionnaires. The qualitative phase is to get the vocabulary 'right' so that questions measure what they are supposed to measure.

The topic under investigation, the characteristics and number of people to be interviewed, the resources available, and the researcher's own particular orientation all influence the researcher when deciding on the type of interview situation to use and this, in turn, affects the

outcome. For example, formal interviews with vulnerable or stigmatised groups of people may make them feel uneasy and threatened and consequently their responses may be poor in terms of length of reply and quality. However, the more informal the interview the more likely the introduction of bias and attempts to identify whether or how much the respondent has been influenced by the interviewer, for example by taping the interview, may also be intimidating with a resultant adverse effect on response.

Participant observation is closely associated with the work of anthropologists because it involves 'joining in' the situation under study and attempting to observe the everyday behaviour of people in its normal and natural context. Since it requires no prior hypothesis, it can avoid structuring the research in a way which may be alien to certain areas of study and, consequently, is particularly attractive to phenomenologists.

The more participant observers take part in the activities of the group the more likely they are to get 'inside' information and 'learn the answers to questions they would not have known how to ask' (Whyte 1955<sup>19</sup>, Liebow 1967<sup>20</sup>). Greater participation, however, also increases the danger of interfering in the activities and changing the behaviour of people in the group under study. Elton Mayo found that the mere presence of his research team, who were observing but not participating, at the Hawthorne Works, Chicago in 1932 was enough to improve productivity. This discovery, that a change in human behaviour could be caused

by sociological investigation, was hitherto referred to as the 'Hawthorne Effect'.

Participant observers, like other social researchers, generally carry out their studies in an attempt to contribute to knowledge which will promote human welfare and solve social problems. They also, however, have an obligation to protect the people who participate in their research. Since participant observers usually have a high level of involvement with the 'subjects' of their research, sometimes balancing these two aims can be very problematic. This raises the question of research ethics.

Ethical questions in social research are often resolved by balancing the cost of questionable practices to research participants against the potential benefits of the research. There are a number of questionable practices which can occur in the course of conducting social research (Sellitz, 1976)<sup>21</sup>. They are concerned with: the way that people become participants, for example, they may become involved without their knowledge, they may be coerced, or they may be actively or passively deceived about the true nature of the research; and, how participants are treated during the research, for example, they may be exposed to physical or mental stress, denied potential benefits of the research, or have their behaviour or character changed. These questionable practices are discussed in more detail in *Appendix 2.2*.

Researchers, therefore, have responsibility to participants when approaching them to take part in the study and while they are participating. However, they also have

responsibility to participants after the research has been completed. For example, researchers must ensure that when participants have been assured of confidentiality and anonymity, they are not identifiable in any reports or publications of their work.

A consideration of questionable practices is particularly important when the participants are considered to be 'vulnerable', for example, children, older people and those with physical disabilities or mental health problems, especially if they are unable to give their 'informed consent'.

To summarise, quantitative methods are structured techniques for the collection of data and generally refer to experiments and large-scale social surveys using postal questionnaires or formal interviews. They are considered to be reliable because they can be replicated. However, their validity, that is whether they are measuring what they are supposed to be measuring is open to question. Qualitative methods are less structured techniques such as informal interviews and participant observation whose reliability is open to question but validity is more assured. They are usually used for gathering data on a smaller scale.

In gathering data, however, many researchers are faced with conflicting demands - to extend enquiries over a large number of instances to take account of a full range of variation in phenomena and, therefore, feel confident about generalising from the results, or to become sufficiently well-acquainted with a small number to make trustworthy judgements. The more one demand is satisfied, the more

frustrated the other.

The range of research methods can be regarded as lying on a continuum from quantitative to qualitative, but many researchers opt for methods which fall somewhere between these two extremes or combine elements of both. This may be because: it is necessary to carry out a qualitative study with a small group of people on the topic under investigation to discover which issues are important before defining the research questions and carrying out a large-scale quantitative study; or the purpose of the study is neither theory-testing nor construction, for example, its aim may be to investigate a perceived social problem, to challenge a generally accepted assertion or, as in the case of this study, to describe the process and outcome of a social policy change.

### LEVELS OF ANALYSIS

The terms 'subjective' and 'objective' are used to refer to micro and macro levels of analysis, respectively.

*".....'subjective' refers to an analysis which focuses upon the understandings or conceptualizations of the social world by members within it, it is an orientation which is concerned to establish the essential importance of meaning in the study and construction of social phenomena. In contrast, 'objective' becomes applicable to a level of analysis which focuses upon the assumed emergent products of social interaction between members of the social world, treating the products as entities amenable to study independently of their constitution by members." (Smart, 1973, p83)<sup>22</sup>*

Adherents of positivism claim respect for the quantitative approach by calling it analysis at the macro level, that is, they are concerned with the 'hard data' of social structure. Macro analysis, however, is dependent

upon empirical evidence which is derived from and situated within an understanding of everyday life which is the domain of phenomenology.

The qualitative approach of phenomenology is considered to be analysis at the micro level because it is concerned with 'soft data' derived from the individual experience of social reality. With its focus on the 'world of everyday life', it is often assumed that phenomenology restricts its inquiry to the mundane, trite, and taken-for-granted and, consequently, micro analysis has tended to be regarded as secondary, either supplementing or filling-out analysis at the macro level. In practice, phenomenology often studies topics which are irregular, controversial, and largely neglected by conventional sociology, including the researcher's own involvement in and dependence upon the everyday world as a resource which is an important consideration when carrying out both quantitative and qualitative research and interpreting findings. Further, it is possible to combine structural theories with qualitative methods of investigation.

Thus, just as macro analysis is not necessarily based on scientific observations, those who conduct systematic observations of everyday life and analyse meanings are not necessarily reduced to micro analysis. In the case of this research, there is a fusion of macro and micro levels of analysis in that a qualitative approach has been used to study one example of a major change in social policy, and an analysis at the micro level has been taken as representative of analysis at the macro level.

### IMPLICATIONS FOR THIS STUDY

As described in the Introduction to this chapter, this study is a small-scale qualitative study of a major change in social policy. The importance attached to interpreting how mentally ill people have experienced this change in the research questions reflects the researcher's view of social reality.

Following Weber, the researcher is concerned with how individuals or groups of individuals experience changes in the social structure and its legislative embodiment, social policy, and also how their experience may ultimately dictate further change. This view of social reality, the emphasis placed on how the 'subjects' of this study (mentally ill people) have personally experienced this change and the vulnerability of these 'subjects' dictated the use of a qualitative, informal approach in conducting face-to-face interviews.

This chapter has shown that with an awareness of one's own biases, clearly defined questions and a professional approach to fieldwork, the qualitative data produced from this research can provide a meaningful insight into this particular area of study which can be a suitable basis for analysis and comparison. What it may lack in reliability should be more than compensated for in terms of validity.

This chapter has also shown that this study does not exist in a 'vacuum' since it is a 'typical' example of the effect of a national phenomenon. As such, the micro level of analysis may be taken as representative of analysis at



the macro level and it will be possible to compare with the findings of other studies and make generalisations.

In Chapter 3, the research methods and findings of studies which have particular relevance to the focus of this research are discussed.

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## C H A P T E R    3

### RESEARCH IN THE MENTAL HEALTH FIELD

#### INTRODUCTION

The purpose of this Chapter is to discuss research methods and findings of studies which have particular relevance to the focus of this research - the experience of people with mental health problems being discharged from hospital to the community and the attitudes of people in the community to them.

As discussed in Chapter 2, the choice of research methods is largely determined by the researcher's view of social reality, and the people or situation to be studied. As the Chapters which comprise the Literature Review in this study (5, 6 and 7) will show, the social reality for many mentally ill people has, until recently, been institution-alisation and physical treatment, in line with adherence to the medical model of care. As a result of the association between medicine and the physical and natural sciences, it is understandable that studies of mentally ill people in the large mental hospitals has tended to be conducted by those who favour the positivist approach. The institution has provided them with a 'laboratory' for the observation, measurement, and manipulation of the mentally ill, to provide statistically significant results.

Due to the large numbers of people suffering from schizophrenia residing in large mental hospitals, there was an obvious concern with the causes of schizophrenia and the efficacy of treatment. As Chapter 5 will show, the large mental hospital was an ideal setting for allocating

'schizophrenics' to experimental and control groups and monitoring, comparing, and measuring their responses to different drug treatments and environmental conditions. The manipulation of human subjects without 'informed consent' and the possibility of harming patients in experimental groups, or denying patients in control groups a relief from symptoms are ethical issues, but they appeared to cause researchers little concern even after MIND (1983)<sup>1</sup> had brought them into the limelight.

There were, however, some notable exceptions to this traditional approach, which treated the mentally ill in hospital as the 'objects' of investigation, especially in the United States of America (USA). For example, Goffman (1961)<sup>2</sup> became a participant observer for a year at St Elizabeth's, an institution for over 7,000 mentally ill people, in Washington, to learn about the social world of the inmates as it was 'subjectively' experienced by them.

Some social scientists in the United Kingdom (UK) who were concerned with the influence of the family on the development of schizophrenia, also used qualitative methods. For example, Laing & Esterson (1964)<sup>3</sup> taped interviews with people diagnosed as 'schizophrenic' and members of their family, to discover the meanings and interactions that developed within the family which made schizophrenic behaviour understandable.

However, despite growing support for 'social' models of care and treatment, the anti-psychiatry movement, and the move towards deinstitutionalisation described by, for example Sedgwick (1982)<sup>4</sup> and C Unsworth (1987)<sup>5</sup>, researchers

continued to rely heavily on quantitative methods, and to develop increasingly sophisticated measuring instruments for use in research with the mentally ill.

From Wing & Brown's (1970)<sup>6</sup> comparative study of three mental hospitals came the Environmental Index, a method of ranking environmental 'restrictiveness' which was related to patients' opportunity for independent activity. The World Health Organisation's (1973)<sup>7</sup> study used the Present State Examination, a structured diagnostic interview technique, with patients in nine different parts of the world. The findings of the above and other studies which are specifically concerned with people suffering from schizophrenia are discussed in Chapter 5.

Given the long-term adherence to the positivist approach to research involving the mentally ill in hospital, and the appeal of its statistically significant findings to funding bodies, it is understandable that the movement of patients from a hospital to community setting was not accompanied by a parallel shift, from the use of quantitative methods to the more qualitative variety, when investigating what happened to patients who were discharged. Evidence of this can be seen in the importance attached to existing, modified, or specially designed measuring instruments for the collection of data, by the larger-scale research projects in the UK.

For example, the study conducted at the Maudsley Hospital (Muijen et al, 1991<sup>8</sup>), which was funded by the Department of Health, involved a comparison of patients on

the Daily Living Program (DLP) with those receiving standard hospital care and replicated a methodology developed by Stein & Test(1985)<sup>9</sup> in Madison, Wisconsin. It used precise measuring instruments and patients were randomly assigned to the experimental and control groups. However, this was an ethical issue, given the predicted success of the DLP based on Stein & Test's findings, that is, that at the end of a year only 6% of those on intensive community treatment as compared with 58% of those receiving routine mental health centre care were readmitted and that the former had fewer symptoms, greater self-esteem, and were more satisfied with their lives than their counterparts in the control group, albeit that this study took place in the USA.

As outlined in Chapter 1, TAPS, who were based at Friern Hospital, had carried out major research into the closure of Friern and Claybury Hospitals, with an emphasis on the use of precise measuring instruments for the collection of objective data, to produce statistically significant results. This work is, therefore, directly relevant to this research since the small 'universe' under investigation is part of the large universe which was quantitatively studied by TAPS. Due to the reliability of the TAPS' findings, they will provide a 'back-drop' to the findings of this qualitative study. Consequently, the TAPS research is discussed in depth in this chapter.

Since the major focus of this small-scale study is how the experience of moving from the hospital to the community has been subjectively experienced by ex-long-stay patients. the researcher has selected three studies which by virtue of

their approach (qualitative), the subjects of their research (people with mental health problems), and the time that they were conducted (also in the 1980's) seem particularly relevant.

(a) A study of the work needs of patients discharged from a Manchester hospital (Birch, 1983<sup>10</sup>);

(b) A study of ex-psychiatric (long-stay and elderly confused) patients of three hospitals in York (Jones, 1985<sup>11</sup>);

(c) A study of the experience of ex-long-stay patients of Claybury Hospital, which was also part of the TAPS research (Goldie, 1988<sup>12</sup>).

The methodological issues raised by these studies, for example, how to contact the subjects and the advantages and disadvantages of using tape recorders in face-to-face interviews with them, were very useful when designing the methodology for this study, which is discussed in Chapter 4. Also, the validity of the findings of these studies, despite their limitation in terms of the small numbers of people interviewed and their restricted scope, served as an important reference point for the findings of the TAPS research and this particular study.

Research on community attitudes to the mentally ill in the UK has been notable by its absence. This may be due to several factors. Firstly, there is the problem of defining a community, for example Smith & Hanham (1985)<sup>13</sup> noted the need to distinguish between spatial and social proximity. Secondly, this subject may not have been a priority because, despite a long-term verbal commitment to community care for

mentally ill people in the UK, there has, until recently, been little practical application of this policy. Thus, people with serious mental health problems had been living for many years in institutions like Friern Hospital 'out of sight' of, and far away from, the people in the communities from whence they came.

There has, however been some research on this subject in the North Americas. According to Warner (1985)<sup>14</sup>, this is because an early interest in community psychiatry in the USA and Canada was accompanied by a concern with the stigma attached to mental illness (p179).

Two North American studies of community attitudes to mentally ill people and mental health facilities have, therefore, been selected for in-depth discussion in this chapter. Firstly, the work of Nunnally (1961)<sup>15</sup>, which was motivated by the desire to discover the existing conceptions of mental illness in the USA and how they could be changed for the better. Secondly, Dear & Taylor's (1982)<sup>16</sup> study of community attitudes to mental health care in Toronto which came from the idea that the successful resocialisation of mentally ill people depended upon their acceptance by the 'host' community. Although the study by Nunnally was conducted more than 20 years before all the other studies selected for in-depth discussion, the researcher concluded that its findings may be significant given that the USA preceded the UK in its deinstitutionalisation of mentally ill people.

The six studies selected for in-depth discussion for their particular relevance to this study for the reasons



outlined are, therefore, now presented in the following order - the large-scale mainly quantitative TAPS research, the small-scale qualitative studies of the experience of ex-patients conducted by Birch, Jones and Goldie, and the afore-mentioned studies of community attitudes by Nunnally and Dear & Taylor.

### THE TAPS RESEARCH

The main questions that TAPS addressed were:

- (a) how was the move from hospital to community being managed?
- (b) had the move proved better for long-term patients?
- (c) how did the transfer from hospital affect elderly mentally ill patients?
- (d) what were the effects of moving acute psychiatric services into local districts?

In 1986, members of the The Personal Social Services Unit at the University of Kent, which also endorsed the positivist approach, began working with TAPS on a cost-effectiveness evaluation of reprovision services. This work involved an examination of the cost of hospital and community services for people leaving the two hospitals, and the relationship between these costs, client characteristics, and service and client outcomes. (NETRHA, 1991<sup>17</sup>)

A large part of the work of TAPS concerned the long-stay (more than one year continuous admission) non-demented populations of Friern and Claybury Hospitals who were resident in late 1985, before the reprovision process began and whom they called the Baseline. They divided this

Baseline into two groups - Leavers and Matches. Leavers were long-stay patients who left hospital during reprovision. They were defined as permanent discharges or those who had remained continuously in the community for longer than a month. Matches were patients remaining in hospital who had been matched with individual leavers in terms of age, sex, original hospital location, casenote diagnosis, and total time in a psychiatric hospital.

These patients were also categorised into annual Cohort Groups which represented the years since the reprovision process began. Thus, first year cohort patients were leavers discharged between September 1985 and August 1986, and their matches. Second year cohort patients were leavers discharged between September 1986 and August 1987 and their matches, and so on. Second year and subsequent cohort groups were also matched on the level of social behaviour problems.

The first interviews were complete assessments conducted on all long-stay patients while in hospital. Second interviews were complete assessments of both leavers and matches, and took place one year after the discharge of leavers. Third interviews took place two years after the discharge of leavers, and so on. Interviews with matches took place in the hospital and interviews with leavers took place in the community, except those who had been readmitted - they were interviewed in the hospital.

A list of the Schedules used in the TAPS long-stay study is contained in *Appendix 3.1*. The Present State Examination, the Social Behaviour Schedule, the Physical

Health Index, the Personal Data and Psychiatric History, and the Basic Everyday Living Skills Schedule all collected objective data of a personal nature. The Environmental Index collected objective data which referred to the environment. It was only the Patient Attitude Questionnaire and the Social Network Schedule which collected subjective data, on a personal and environmental level, respectively. A mere glance at all these Schedules, the main tools of gathering data in the TAPS study, left the researcher in no doubt that those whom they called the 'subjects', the long-stay patients, were, in fact, the 'objects' of the research, since they were given no opportunity to speak for themselves. Thus, although the TAPS study produced statistically significant results, the researcher questioned the validity of some of their work.

The only purely qualitative research with patients or ex-patients carried out by TAPS was an observational study of patients interacting in the larger of Friern's two coffee bars, to collect data on the quality and quantity of contacts, so that the validity of data derived from the Social Network Schedule could be tested (Dunn et al, 1990<sup>18</sup>). This Schedule was specially designed to find out how to define the friends of long-stay patients (since one stipulation of reprovision made by NETRHA was that patients be discharged with their friends), and to ascertain whether discharged patients would begin to establish social relationships with ordinary members of the public (a change which ought to be reflected in the composition of their social networks).

TAPS encountered several problems with this study, for example, how would they be able to remember who patients were from week to week, without directly asking their names? They decided to give each patient a pseudonym based on some impression or physical feature. Also, how could they counteract the patients' interest in them, as observers. They gave bland, negative responses to all the patients' questions and refused to give in to begging. As a result, the interest only lasted for a couple of weeks and they were treated liked other patients.

Further, how were they to interpret and record the behaviour being observed due to the low level of social interaction. Eventually observers developed four categories or types of behaviour into which most patients fitted ('helpers', 'friends', 'nuisances' and 'asocial') which could be used as a short-hand method for recording data, and they became experienced in giving observed behaviour its appropriate social weight.

Reference has already been made to the characteristics of the Friern long-stay patients (non-demented) which were compiled from the TAPS Baseline Survey (See *Appendix 1.1*). In addition, TAPS (O'Driscoll et al, 1993<sup>19</sup>) found that the mean age of long-stay patients was 60.8, 21% had been first admissions and 11% had had more than 10 previous admissions. Also, the concept of the 'burnt-out schizophrenic' was challenged by 41% of patients with 20+ years admission who had florid psychotic symptoms. Further, there were a significant number of new long-stay patients accumulating (22% with one to five years stay). TAPS (Knapp et al,

1990<sup>20</sup>) found that an average of 23 long-stay patients per year died, 40 were discharged, and 40-50 new long-stay accumulated.

TAPS (Jones, 1993<sup>21</sup>) also found that 70% of long-stay patients suffered from negative symptoms associated with institution-alisation (avoidance of social contact, blunting of affect, muteness or poverty of speech). Approximately 20% required daily nursing care with regard to the bodily system. Hostility was named as the worst problem by staff for 7% of patients (coming second only to hygiene for 23%) which was an important consideration given public concern about the risk of violent behaviour by discharged psychiatric patients. Critical disabilities such as blindness, deafness, incontinence, immobility, and dyskinesia were also considered to be an impediment to placement in the community.

TAPS (Dunn et al, 1990<sup>18</sup>) found ample evidence of an active social life and social network among long-stay patients. Much of the observed social activity in the hospital club was stimulated by an economy based around the purchase and exchange of tea and cigarettes, and the borrowing and lending of small change among patients categorised as helpers, friends, nuisances, and the asocial.

It also became apparent to TAPS that the social interaction of long-stay patients could change dramatically over short periods of time which raised the hope that asocial patients may be able to develop social bonds in the community given the right atmosphere, and that the hospital club population might hold a clue to what the right

atmosphere might be. However, if the most socially able patients continued to leave the hospital first, there were serious doubts that the asocial patients left would be able to form viable social groups in the community.

TAPS (Jones, 1993<sup>21</sup>) found that a strong selection bias was operating in the first three years of community reprovion (1985-88). The patients selected were younger and had spent less time in full-time psychiatric care, probably because 42% were accumulation patients. They were also more likely to have expressed a desire to leave hospital when assessed, had fewer social problems, a wider social network, more likely to be/have been married/co-habiting and less likely to have a diagnosis of schizophrenia.

TAPS (Anderson et al, 1993<sup>22</sup>) found that after one year in the community, the patients discharged in the first three years greatly preferred life in the community and were appreciative of their homes. Their mental state and social disabilities were stable and they had made new friends who were drawn from ordinary members of the community. However, since these leavers were younger than their matches still living in the hospital, and had less physical disabilities (incontinence and impaired mobility), the outcome in the community for all patients in the closure programme may not be so favourable.

TAPS (Dayson, 1993<sup>23</sup>) found that there was not a marked increase in vagrancy, crime, suicide, and death due to natural causes after the first year of local reprovion, in the first leavers (1985-88). Mental deterioration most

often caused readmission and on recovery most returned to their community home. However, 6% were readmitted and remained in hospital for a year or more proving 'more difficult to place'. Also, first leavers did not have as many problems of social behaviour as those still living in hospital which was likely to make them more difficult to resettle. TAPS (Anderson et al, 1993<sup>22</sup>) also found that leavers considered medication of less help than their matched stayers.

With regard to the cost of care, TAPS (Knapp et al, 1990<sup>20</sup>) found that, as at 1986-87, revenue costs for in-patient care at Friern was £49.92 per day and the mean cost in the community was £270 per week per patient. Accommodation and day-to-day living expenses accounted for the largest share of the cost of care in the community and there were significant differences in the cost of ex-patient care. The lowest was £47 per week for a man living independently in a one-bed flat he shared with a friend, with weekly social worker visits and monthly appointments with his General Practitioner (GP) and at out-patients. The highest was £568 per week for a woman living in a staffed group home, managed by the health authority with a high level of support from GP, psychiatrist and social worker and who had spent three months back in Friern.

TAPS also found that men on average cost £20 per week more than women because they were less capable of self-care and were, therefore, directed to more highly staffed or closely supported and, subsequently, more costly placements. The care of older patients was less costly because they are

less demanding with regard to requiring employment or further education programmes.

After a c.10 year continuous stay prior to discharge and/or a high proportion of a person's lifetime spent in hospital, the cost of care in the community increased quite markedly. This was interpreted as an institutional effect. Also, people with high scores for negative symptoms (social withdrawal, flattening of affect, and poverty of speech) who are more difficult to place and those with more social behaviour problems and men with weak social networks were also supported in the community at higher costs. The marital status, ethnic origin, attitude, physical health, original psychiatric diagnosis, reason for admission, and number of admissions of patients had no effect on community cost.

TAPS (Knapp et al, 1990<sup>20</sup>) concluded that the cost of community reprovision packages once relocated were no larger and probably smaller than their present hospital residence costs. However, this was not the conclusion reached by an anti-closure Friern Consultant (Dr M Weller) when speaking at a conference on homelessness and mental illness organized by CONCERN in 1991. He stated that at Friern it cost £13,000 per year to look after a patient in Friern whereas in the community it cost more than £30,000 (The Guardian, 1991)<sup>24</sup>.

TAPS (Knapp et al, 1990<sup>20</sup>) conceded that there may have been several reasons for expecting higher future costs: early movers were less dependent with few symptoms; new capital projects were not needed for first leavers because



existing day and residential facilities were not yet operating at full capacity; and, the supply price of certain types or grades of staff may rise with the growth of demand for them in the community.

### THREE QUALITATIVE STUDIES

#### The work needs of ex-psychiatric patients in Manchester

Birch's (1983)<sup>10</sup> study provided a space for ex-patients 'to speak out for themselves' (p1). Birch conducted semi-structured interviews, with the help of a check-list, with psychiatric patients from three acute admission wards in a Manchester hospital, just after official notification of discharge and, again, within the third month of discharge. A second Manchester hospital refused to take part in the study because it was concerned about "*...the over-exposure of patients to research enquiries which are not of immediate and direct benefit to the patients themselves*" (p7).

Birch's sample from these wards were all those of working age, who were discharged during eight consecutive weeks, who had been living in Manchester prior to admission, and who were expected to live there, after discharge.

The aim of the first interview was to get an idea of their past employment experiences, how these related to present illness, their expectations of future employment, and how any work experience or support in hospital helped towards this. Birch required a nurse to introduce her to the patient and the use of a quiet side-room. She spent 10-15 minutes chatting, to put them at ease and give them an explanation of the study. She felt this was ethically

necessary, but sometimes she found it difficult to explain that she was only gathering information and that she was not going to find them a job. Most were happy to take part in the study in the hope that it would inspire future action but, for some, the explanation was superfluous and they just wanted to get on with it.

Birch tried to ensure that patients had at least one hour free for the interview but sometimes they were interrupted and had to continue later. Interviews lasted 20-60 minutes depending on how talkative patients were. At the end, she explained that she would be contacting them again at home about the second interview.

Nursing staff informed her of 53 patients who were being discharged in the eight week period. Eight had left before she arrived and nine were excluded because they did not meet the criteria, or had communication problems.

The patients who had been interviewed in hospital were contacted at home, first by telephone or letter. If there was no reply to the second letter, Birch tried visiting patients and, if this failed, she tried to discover what had happened to them via the hospital social work team.

Of the 36 patients who completed the first interview, 11 were lost by the second interview because: they had not replied to her letters; they were not in when she called; they were unwilling or too unwell to be interviewed; or they had disappeared. Nineteen were interviewed at home, the other seven in hospital or hospital-based facilities.

The aim of the second interview was to see how they were progressing and how their experience matched-up to

their expectations. During the home interviews, Birch became aware that she was causing them to think deeply about their present situation in a way they might ordinarily avoid, because it made them feel uncomfortable. She concluded, therefore, that it would be unethical to ask them about further hypothetical or alternative ideas without having something concrete to offer them. Third interviews had been planned for the sixth month out of hospital but these did not take place because the processing of information from the first and second interviews took much longer than expected.

Forty-five interviews were taped and sixteen were recorded in note form because some patients were not happy about being taped. Interviews were written-up immediately afterwards and Birch noted the way she felt about the interview, and the general emotional response to herself and the questions. She admitted this was subjective but since it is often tone of voice or facial expression which give the real meaning of a utterance, she believed this gave context to the written reproduction of the interview.

Much of this study was a straight transcription of the interviews. The interviewees' 'stories' were mainly presented in their own words and, through these words, the researcher caught a glimpse, a feeling of what it meant to have suffered a mental illness, to be faced with trying to find work, or to cope with being unemployed. Although the people in this study were unique, Birch concluded that the negative feelings expressed were likely to be shared by many people in similar situations throughout the country.

Birch interviewed 18 men and 18 women. The modal age range of those interviewed was 46-50, and more than two thirds were over 40. Half the group stated depression as their main illness and in some cases this had led to attempted suicide or was complicated by alcoholism. However, there was evidence of schizophrenia in some of their accounts and nine people also had physical disabilities. Their length of stay in hospital was one week to seven months, however almost half had only had a short stay (one to three weeks). Only 10 were first admissions and 21 had a long history of admission. Only seven were working prior to being admitted and several felt that unemployment had contributed to their illness in terms of lack of money, despair of finding work, inability to cope with having nothing to do, and being at home all the time.

Occupational Therapy (OT) in hospital was considered to be beneficial because it broke up the day and helped to fill in time. However, for some the tasks were too simple, not satisfying and not paid. Others did not like working on their own, the lack of a time structure and the measurement of performance.

People liked working in Day Centres because they were a step between hospital and home, the hours were like a job, they had the company of others, and not too much pressure, which allowed them to build their self-confidence. However, some found the activities childish and Birch concluded that Day Centres could also be a work substitute and prevented them looking for work although money was an incentive.

Birch found that, for the majority of the people interviewed, after-care had been taken up with discussing domestic and emotional matters - their occupational needs had not been addressed. She described how employment is important for the well-being of ex-patients and that even in times of high unemployment, work retains its status. Since Social Security covers only basic needs, lack of employment makes them financially dependent and lacking money to spend on activities they enjoy. Birch, therefore, recommended that ex-patients must be helped to gain work or hang on to jobs that had been kept open for them by sympathetic employers.

Birch also described how looking for work is daunting in times of high unemployment. One needs confidence, perseverance and the longer the time unemployed, the harder it becomes. However, ex-psychiatric patients have additional problems - are they fit for work, are they too old, how do they look for work, will employers want an ex-psychiatric patient, should they just resign themselves to being sick, should they not apply to avoid refusal, can they hide their illness, and how can they overcome the fear of the stigma when they are revealed as being mentally ill? As one interviewee observed 'with millions unemployed, what chance have I got' (p76).

Birch, therefore, recommended that recovering mentally ill people also need support to combat inactivity even in times of high unemployment via alternative activities, for example, community, adult education, leisure centre, and voluntary work. Further, since some ex-patients do not want

to be associated with the hospital and the label of mental illness, an outside agency should help with this and there should be liaison between hospital and community-based services.

Ex-patients of three psychiatric hospitals in York

Jones' (1985)<sup>11</sup> study of ex-psychiatric patients from the Naburn, Clifton, and Bootham Park Hospitals in York covered two groups of patients - a long-stay group of 50 patients who had been in hospital continuously for one year or more, and were discharged in a two year period, and a random sample of 100 elderly confused patients discharged in the same period. They were living in a variety of settings, for example, own home, with family, local authority homes or hostels, voluntary organisation accommodation, private registered homes, and in hospital.

One of the questions they set out to answer was "how does the patients' quality of life outside the hospital compare with the quality of life on the wards from which they were discharged?" (p37). In order to establish what had been gained and/or lost by discharge to the community, three tasks were undertaken - the construction of a Quality of Life scale sufficiently flexible to cover life both in hospital and in the variety of settings to which the patients had been discharged, visits to the hospital wards where the two groups of patients had been treated, and the matching of hospital and community conditions for each individual patient.

Jones discussed the inappropriateness of existing scales of, for example, life satisfaction, social functioning, social activity, and standards of living for use in this study, and outlined how a Profile of Quality of Life Criteria was constructed. The starting point was Maslow's (1945)<sup>25</sup> 'hierarchy of human needs'. According to Maslow, there were five basic types of human need, and each level had to be largely satisfied before the individual could progress to the next.

- 1) Physical Survival - food, drink, sleep, and shelter.
- 2) Security and Safety - stability of accommodation, support and protection.
- 3) Purpose in Life - work, leisure activities and companionship.
- 4) Independence and Freedom - material environment and living space.
- 5) Aesthetic and Intellectual Satisfaction.

It was not felt that Maslow's fifth level was of general relevance to the two groups of ex-patients in Jones' study, but the first four provided a framework for the scale.

This framework was amplified with items from Drewnowski's (1974)<sup>26</sup> 'level of satisfaction' scale and Kennie & Arnott's (1973)<sup>27</sup> work on 'cornerstones'. The final format consisted of ten items, each capable of being judged on a three point scale (needs fully met, partly met, and unmet), and applied to the conditions in which individual patients had lived in hospital, and to their circumstances at the time of the interview.

Jones (1985)<sup>11</sup> noted that:

*"Interviewing people who have been hospitalised for mental illness is a sensitive and often difficult operation. Some do not wish to be interviewed, and prefer to forget their time in hospital. Some are difficult to trace, as they move (or are moved) from one address to another. Some, in continuing distress or confusion, may misunderstand the purpose of the interview; and some may not give coherent replies to questioners". (p2)*

*"Previous experience of interviewing psychiatric patients suggested that formal questionnaires would be off-putting and that tape-recording might inhibit free discussion." (p39)*

As a result, all the General Practitioners (GP) for the 150 patients were consulted first to find out if the interviews were likely to cause distress. Also, interviewers used an agreed check-list and wrote up case-studies immediately after interviews, supplementing information from patients and their relatives by enquiries of health and social services agencies and cross-checking where possible.

For the first group of 50 patients, there were two refusals by GPs and five refusals by patients or their carers. Three people had died, four were discarded as not meeting the criteria and two had duplicate records. With the elderly confused group, there were two refusals by GPs and four refusals by patients or carers. Thirty-five people had died and two were unable to be found.

Some of the patients proved difficult to trace because they had moved several times since discharge. Interviewers frequently had to contact relatives, neighbours, Community Psychiatric Nurses (CPN), and social workers, to find the patients and, even when the address was established, it was sometimes necessary to make several visits before the



patient was found at home, or agree on a convenient time for the interview.

Many patients, especially the elderly confused group, were unable to make responses, so the answers to some questions had to come from their carers and, therefore, reflected their estimate of the situation. It was also noted that some people who were depressed, or who had failing memories, would not be the best of witnesses. However, it was acknowledged that, although the perceptions of patients and their carers differed from that of the professionals, they had their own validity.

Jones adopted two conventions in writing-up the research. All the people who were the subjects of the enquiry were referred to as 'patients' throughout, rather than ex-patients, clients, residents, or any other term appropriate to a particular context. Jones did not intend this to imply a particular adherence to the medical model of care, nor that a period of treatment in a mental hospital conveyed any lasting characteristic on those who had undergone it. This term was merely used to facilitate reading. Due to a dislike of referring to patients by case-numbers, Jones gave all the subjects of the research pseudonyms - the long-stay patients were allotted names beginning with the letter L, and the elderly confused patients were given names beginning with P. None of these names resembled their real names.

A total of 90 patients were interviewed. The long-stay sample (34) were evenly divided between men and women and covered a wide age range (24-82). The length of stay in

hospital varied from just over one year to 43 years and over half (20) had a diagnosis of schizophrenia. The older patients tended to have one admission and a long hospital stay while the younger ones had multiple admissions and shorter stays. At the time of the interview, only five were living in their own or family homes, the rest were scattered between local authority homes or hostels, private registered homes, group homes, flats and lodgings. None were in prison, one was sleeping rough and two were back in hospital. Jones et al (1986)<sup>28</sup> noted that York had a homefinder who believed in a highly individualised process of intuitively matching patient and setting and most patients seemed to have made a reasonable adjustment.

Jones (1985)<sup>11</sup> found that of the 57 people interviewed in the elderly confused group, 42 were women, 46 had a diagnosis of senile dementia, and 23 were back in hospital. Only ten were living in their own or family homes, the rest had been discharged to local authority or private registered homes or to sheltered housing. Those in their own homes were less well-supported than younger long-stay patients. When there was only a mild degree of senile dementia, the family was large enough to spread the burden of care and there was enough money to cushion the situation. When their condition was severe and disruptive and there were physical complications such as blindness or incontinence, the burden of care fell exclusively on one family member, usually a husband or wife who was also old and often in failing health. When coupled with scant financial resources, this situation could be intolerable. Neighbours and friends

offered little help and friends were scarce. Health and social services were initially involved but visits tended to tail off after a few months.

Jones identified a need for a community care plan which offered a possibility of stable living conditions with adequate support rather than the hospital discharge plan which was inadequate, for example, it did not list GP or outpatient services.

With regard to the question of quality of life, this proved difficult to answer. Jones noted that it is often taken as axiomatic that any kind of life in the community is better than remaining in the mental hospital. However, they found that patients go out into many varied circumstances, and not all of these are beneficial. Most of the patients were still living in fairly institutional surroundings, therefore, it was not possible to indicate which of the two was superior - hospital or community care.

Patients' own homes scored well on choice and autonomy but not on health care, personal care, activities and companionship. Local authority homes provided good personal care but scored poorly on health care, privacy and activities. Private Homes (usually run by psychiatric nurses) provided good personal and health care and activities but were often cramped and lacking in facilities. Mental hospital wards provided best for basic survival needs, health care and activities but not for personal choice, privacy, autonomy and stability, since they might be moved to another ward or discharged at any time.

The study revealed the great complexity of care in the community, not only in the different settings to which people are discharged, but also in the difficulties which health and social services have in working together when they have different legislative bases, different working styles, different patient groups, differing planning and budgeting cycles, and different professional backgrounds. This study also highlighted the problems experienced by small voluntary organisations in trying to work with the statutory giants, the isolated pockets of private care and the difficulties of co-ordinating statutory, voluntary and private services with GP care.

The experience of ex-long-stay patients of Claybury Hospital

Goldie (1988)<sup>12</sup> acknowledged that both mental health professionals and sociologists had been negligent in attempting to research the views of mental patients. He, consequently, adopted a methodology that "... *places priority on listening to what the subject has to say for themselves and how they view their situation*" (p5). This was because he believed that ".... *concern with 'objective knowledge and the measurement of human experiences has a valid role to play in assessing aspects of the services provided for patients but it cannot claim a monopoly of wisdom*" (p5).

Goldie noted that positivist methodology had been criticised in recent years for the way "...*its instruments distort the reality and fail to comprehend the subjects reality*" (p5). Moreover, "...*such instruments tend to*

*conceptualise the 'problem' in the professional's terms rather than those of the client" (p5).*

Goldie wanted to interview 50 ex-patients from Claybury Hospital who had been long-stay (five years residence), or with multiple admissions in a five year period, who were under 65 years of age, and were discharged between 1980 and 1985. He decided not to seek to scale or measure the quality of life of the people being interviewed, although the issues explored in the Interview Schedules he compiled reflected a concern with this. These Schedules contained questions referring to Contact with Services, Daily Life, and Domestic Life, and Goldie adopted a conversational approach to the interviews.

The manner and method of approaching people and conducting the interviews raised ethical questions and posed practical and personal problems for Goldie. For example, the lack of accurate information on the patients discharged meant he had to do a great deal of very time-consuming and tedious clerical work to extract the relevant information from forms and records. The access to, and confidentiality of, this material was also an ethical issue.

Goldie sent letters to the ex-patients seeking their informed consent to be interviewed, telling them about the project, and stressing his independence from the hospital but, how else would he have known they had been patients there? Consequently, he tended to be regarded as an extension of the services, another person asking questions, but providing nothing else. Also, with people back in hospital and those in some form of sheltered accommodation:

*".... their 'guardians' acted protectively towards their charge and took it upon themselves to decide whether or not the subject was willing to be interviewed. As long as they blocked access to the subject it was not possible to reach the point of offering informed consent to the subject." (p90)*

Goldie was only able to find 27 of the original sample from their last known address. He felt like a private detective and spent a great deal of time on abortive visits. It was also difficult to decide when to abandon the search. He found that the more recently discharged patients were less likely to agree to be interviewed because they feared the outcome.

Like Kay & Legg (1986)<sup>29</sup>, Goldie found that some people had little to say for themselves, giving coherent but monosyllabic replies. There was also the problem of veracity, especially with people who seemed quite disturbed. He admitted that he sometimes felt uneasy about how people would behave, but did not actually have a problem with personal safety.

Goldie interviewed 26 ex-patients, men and women, aged 20-65, mainly with a diagnosis of schizophrenia. Half the interviews were taped, the remainder were conducted by making written notes since he found that some ex-patients were unwilling to have their interviews tape-recorded.

Goldie found that there was a general level of satisfaction with housing conditions. However, he also found much evidence of deprivation in the physical conditions in which ex-patients were living in the form of neglect and the need for intervention. Also many people were living very isolated lives with few social contacts.

There were few, if any, meaningful social activities for ex-patients, and there was a lamentable lack of provision for evenings and weekends and schemes for meaningful employment especially in times of high unemployment. Many expressed a desire to work and to earn more money and reminisced about the jobs they had done while in hospital.

There have been a number of other qualitative studies which attempted to trace ex-patients to find out what had happened to them, which all involved small numbers, were beset with methodological problems, for example, finding the ex-patients, securing their cooperation, eliciting coherent replies and which, like Birch and Goldie, also highlight the lack of employment for ex-patients and the negative effect of this on their financial situation.

For example, McLean's (1987)<sup>30</sup> study of what happened to a cross-section of patients discharged from Runwell and Rochford Hospitals found less than a third of ex-patients in employment. Also Kay & Legg's (1986)<sup>29</sup> study of 100 discharged patients (long-stay, short-stay, and first time admissions), who were chosen through different forms of housing tenure and social service records found 91% unemployed. Further, Rayner & Quarry's (1986)<sup>31</sup> study of the experience of 99 ex-patients living in boarding houses in Clacton found no one in open employment and 71% with no sheltered work.

Although Day Centres endeavour to provide some of the features of the working environment (structure, purpose, and opportunity for social contacts) Goldie found that these

were not popular with people in the study. He recommended that these Centres should be run by clients, with staff acting as facilitators and enablers. Also, the voluntary sector role could be enhanced in this because they have expertise at providing services which are divorced from the social control aspects of most statutory provision.

According to Goldie, people were still likely to be stigmatised by themselves or others by the 'ex-mental-patient' label which effectively restricted them to associating with others similarly labelled. He found some striking examples of the importance of friendship networks, which TAPS had observed in patients, among ex-patients and how they relied on each other for support.

Even those who had attempted to enter 'normal' society only did so with limited success, with the exception of housing, for example, those on deprived local authority housing estates shared the general deprivation with their neighbours. They also had an equally low income because they were on a similar level of state benefits. However, it was difficult to ascertain what level of deprivation should be attributed to being an ex-patient and what to having an inadequate income. Goldie argued that the greatest contribution to their 'normalisation' would be to significantly increase their incomes so they could share with other normal people, activities such as going to the cinema, a public house or the occasional purchase of clothes.

Goldie found that the services being provided for people were lacking coordinators. They all knew someone to



run to with problems but that is not the same as having someone who has an overall sense of their biography to maximise their opportunities. He therefore recommended the use of individual care plans and keyworkers, which mirrors Jones' observation of the need for a community care plan. Goldie also identified an urgent need to keep in touch with and monitor the progress of people discharged.

Goldie noted that, at times, the findings might seem to question whether the ex-patients would be better off cared for in hospital and support those campaigning against closure. However, very few people expressed a desire to be in hospital. Whatever their circumstances, they expressed a preference to retain the autonomy and control over their lives they had gained since leaving the hospital. Having control over one's own finances, even if it meant the worry of paying heating and other bills, was valued as a move away from the dependency and restrictions of hospital life.

Just surviving outside hospital was seen as a great achievement by some who had been led to believe they would never get out hospital. There were also a few notable examples of people, who had been 'hopeless' cases in the hospital context, who were not just surviving but living active lives, developing circles of acquaintances, and being accepted by their neighbours.

Goldie, therefore, concluded that to see the choice as hospital or not is inappropriate. This is because regular meals, clean clothes and a warm environment can be provided in many other contexts other than the hospital, and a major theme of the study was the diversity of the needs of ex-

patients, as among the population at large. The study, therefore, suggested the need to produce a diversity of services to meet these needs, and Goldie recommended that planners and providers should find out what clients think of the services via research and help them to articulate what they would like to see provided.

Further, since there is a need to provide maximum diversity in day, evening and weekend services and activities and, in view of the limited resources available to health and local authorities, it makes sense to also encourage people to use existing services, for example, joining a pottery class at an adult education centre with the help of a keyworker who can initially support them and the teacher.

Goldie acknowledged that people may need temporary 'asylum care', however, this should not be the old Victorian asylum variety. Instead, the closure of large mental hospitals should be used as a way of righting the historic wrongs done to inmates and as an opportunity to develop services that reflect the diversity and variety of the needs of the people who will use them.

#### STUDIES OF COMMUNITY ATTITUDES

Nunnally (1961)<sup>15</sup> employed a wide range of research methods, from those used in controlled psychology experiments to those typical of journalistic studies, to measure the attitudes of, and information held by the general public, experts (psychologists and psychiatrists) and the mass media about mental illness.

The survey studies were first conducted with an 'opinion panel' of 400 respondents, the majority of whom lived in central Illinois, which was an approximate miniature of the population of the USA in terms of education, sex ratio, income, religious affiliation, and age over 15.

One of the biggest hurdle's for the researchers working with Nunnally was the construction of adequate questionnaire-type measuring instruments. The first step was to gather a sample of expert opinion statements from mental-hygiene books, professional publications, and information pamphlets. Samples of public opinions were then taken from 200 detailed personal interviews, eight interviews with the mothers of children in psychotherapy, and twelve interviews with the wives of men who were in mental hospitals. As a result, they obtained over 3,000 statements relating to the causes, symptoms, prognosis, treatment, incidence, and social significance of mental health problems. Those with duplicated meanings were removed and this larger collection was reduced to 240.

After pilot studies to test the clarity of the questions, instructions and rating procedures, and application of a technique for measuring bias, a questionnaire with 240 opinion statements, with a seven step rating scale, Disagree to Agree, 1-7, were administered to the opinion panel. A factor analysis of the responses was then made to uncover some major dimensions of public information about mental health phenomena. The statements

with which people strongly agreed or disagreed were removed and the questionnaire was reduced to 180 items.

The responses to these 180 items were also factor-analysed to obtain ten general dimensions of public information which were used as yardsticks in further studies, and allowed comparisons to be made of the views expressed by the general public, experts and the media.

Nunnally found that the stigma attached to mental illness was very general, across social groups and attitude indicators. The mentally ill are considered as being all things 'bad'. The facts only show that they are sometimes unpredictable and dangerous but the average man generalizes to the point of considering the mentally ill as dirty, unintelligent, insincere and worthless, probably due to lack of information about mental illness. However, the public's interest in mental health topics is motivated by a panicky 'need to know', they want information that will relieve immediate personal threats and will reject messages that do not supply solutions.

Nunnally also found that the media presentations of the mentally ill, which closely matched public attitudes, were stylized to fit the requirements of fiction and drama in the context of horror, sin and violence. Also, the symptoms of mental illness were exaggerated and the causes and treatment over-simplified and often erroneous.

Nunnally described how GPs play an important role in the treatment of mental health problems, acting as 'gatekeepers' between the public and experts. He found that younger better-informed physicians tend to have 'better'

attitudes towards mental patients and are more likely to treat mental problems rather than referring them to experts.

Dear & Taylor (1982)<sup>14</sup> developed a theoretical model of accepting and rejecting community attitudes to mental health care based on the relationship between: external variables and beliefs: beliefs and attitudes; attitudes and behavioural intentions; and, behavioural intentions and actual behaviour.

They outlined three sets of external variables which lead to salient beliefs about facility impacts, the mentally ill, and the neighbourhood: characteristics of residents; facility and user characteristics; and, social and physical characteristics of the neighbourhood. These beliefs may be personal, shared, and/or inherited, and their origin is dependent on social influences and contextual factors. Their complex interaction determine the behaviour intentions and actual behaviour of an individual or group.

They developed two sets of scales to test their model of community response. The first characterised community beliefs about mental illness along four dimensions: authoritarianism; social restrictiveness; benevolence; and, a pro-community, anti-institutional ideology. The second represented respondents' beliefs about the suitability of their neighbourhood as a facility location by addressing six dimensions of neighbourhood - activity, design, safety, predictability, integration, and evaluation.

Their sample was stratified into low, medium, and high socio-economic status groups. They compared urban and

suburban groups, with and without facilities, using purposive and random sampling techniques, respectively. They also tested the anticipated property value decline in five Toronto neighbourhoods.

The desired completion rate of 66% was not achieved because of high refusal rates and high absentee levels during a 'holiday' month. There was a lower response in lower class neighbourhoods principally because of the numbers of residents who were too old or ill to respond, or had language problems. The low response rate could not be explained by reluctance to answer questions on attitudes to the mentally ill because the study was introduced as 'Community Attitudes Toward Neighbourhood Public Facilities' and its real nature was further disguised by moving from general to specific questions.

Dear & Taylor found that beliefs about mental illness were more important than facility or neighbourhood characteristics in determining community attitudes towards mental health facilities which is primarily a response to users. Younger people, those who were single or separated, women, people who lived in rented accommodation, with a higher education level, without children, who did not attend church, and who were familiar with mental illness or a mental health facility were more sympathetic than older people, those who were married or widowed, men, home owners, with a lower education, with children, church attenders and who had no familiarity with mental illness or a mental health facility. Race was not a significant factor.

They also found that respondents rating facilities as undesirable were more likely to engage in opposition. Residents' fears focussed on property value decline, increased traffic, and users' behaviour in that the more unpredictable this was perceived to be, the greater the rejection or avoidance was likely to be. Negative attitudes were strongest within one block of a facility and after six blocks, the impact appeared to be neutralised. Attitudes were also affected by the type of facility, for example, residential facilities were the least acceptable and the larger the size, the greater the rejection. Visibility was also an important aspect.

Dear and Taylor found no significant change in the volume of sales before, after and during the opening of a facility. The small reduction in property values in some neighbourhoods could not be conclusively linked to the facility - market movements were still due to neighbourhood desirability and the characteristics of the property.

According to Dear & Taylor, accepting neighbourhoods are more likely to be those in which residents have few children, are well-educated and predominantly English-speaking. Further, the population is relatively transient and high density, and there is a mixture of land use in the area - commercial development, public open space and residential. Rejecting neighbourhoods are those in which there are younger children, low education levels, non-English speaking groups, where the population has been relatively stable for five years, the population density is low and where land use is predominantly residential.

## SUMMARY

This chapter has shown that the use of quantitative methods in research with mentally ill people in hospital has been the 'norm' and that, although hospital and community settings are very different, in terms of how ex-patients perceive, and adapt to, their new environment and how they in turn will be perceived and expected to behave in the community, the movement of patients from the hospital to the community has not been accompanied by a change to a more qualitative approach to studying what has happened to them.

Four recent studies in England on the experiences of discharged patients were selected for in-depth consideration because of the relevance of the location of their study (TAPS at Friern and Claybury), their qualitative approach (Birch 1983<sup>10</sup>, Jones 1985<sup>11</sup>), or a combination of both (Goldie 1988<sup>12</sup>). In summary, these studies found:

(a) There are a number of impediments to the resettlement of discharged patients - negative effects of institution-alisation, symptoms of schizophrenia, physical disabilities which often require nursing care, social behavioural problems, and the stigma of the ex-patient label.

(b) Ex-patients, especially those suffering from schizophrenia, do require periods of hospitalisation after discharge.

(c) There is a great diversity in the destination of ex-patients in the community and also in the cost of their care which is affected by sex, age, length of stay in hospital, symptoms of schizophrenia, speech problems and social behaviour problems.



(d) There is a great complexity of care in the different settings in which ex-patients are found - own/family homes, local authority homes/hostels, private registered homes, group homes, flats and lodgings. These all have implications for level of personal care, health care, privacy, activity, autonomy, personal choice and stability. Also, an institutional environment can just as easily be created in the community.

(e) Ex-patients have occupational needs which are not being met with a resultant negative effect on finances and, therefore, the ability to engage in social activities.

(f) There is a lack of meaningful social activities for ex-patients in the community, especially at evenings and weekends.

(g) There is a need for a range of daytime activities to meet varied needs. The type of activities offered at Day Centres are not popular with everyone. There should be other ways to combat inactivity especially in venues which are not stigmatising, eg. in adult education and leisure centres.

(h) There is a problem of socialisation in the community. Some ex-patients are very isolated in the community with few social contacts. Many ex-patients rely on the friendship networks formed in the hospital.

(i) Ex-patients greatly prefer life in the community and are appreciative of their housing conditions, although there is evidence of physical deprivation in the form of neglect.

(j) Ex-patients have no desire to return to hospital, they value their independence and there is evidence of the success of so-called 'hopeless cases'.

(k) There has been a lack of coordination in services being provided and monitoring of progress.

(l) Health and social services have experienced difficulties in working together because of different working styles, patient groups, planning and budgeting cycles, and professional backgrounds. Voluntary organisations have experienced problems in working with statutory agencies, and there have also been problems in coordinating work done by the statutory, voluntary and private sectors.

This chapter has also shown that research in the UK on community attitudes to mentally ill people and community mental health facilities has been notable by its absence. Two North American studies were, therefore, selected for their relevance to this research.

Nunnally (1961)<sup>15</sup> drew attention to the stigma attached to mental illness and showed that perceptions of mentally ill people as unpredictable and dangerous led to them being seen as 'all things bad'. Media representations associated with horror, sin and violence reinforced negative stereotypes. He also highlighted the role that GPs could play in changing these negative perceptions.

Dear and Taylor (1982)<sup>16</sup> showed that beliefs about mental illness were more important than facility or neighbourhood characteristics in determining attitudes to mental health facilities, which was primarily a response to users. Younger people, single/separated, women, those

living in rented accommodation, with a higher education, without children, who did not attend church, and were familiar with mental illness or mental health facilities were more sympathetic.

Residential facilities were the least acceptable. Fears focussed on property value decline, increased traffic, visibility and the unpredictable behaviour of users. Negative attitudes dissipated with increased distance from the facility, however, those who rated facilities as undesirable were more likely to engage in opposition. 'Rejecting' neighbourhoods were those in which there were younger children, low education levels, non-English speaking groups, where the population had been relatively stable for five years, the population density was low and where land use was predominately residential.

This chapter has, therefore, served three purposes. Firstly, it has validated both the focus and approach of this study. It has demonstrated that there is a need for more qualitative research on the experience of people with mental health problems being discharged from the hospital to the community since this is the most appropriate approach to enable ex-patients to articulate their response to the major change in policy and also their diversity of needs so that an appropriate range of services may be provided. It has also highlighted the need for research on community attitudes to mentally ill people and community mental health facilities in the UK where communities have already been targeted to play 'host' to ex-patients as a result of large hospital closure in an attempt to define the characteristics

of 'accepting' and 'rejecting' communities and distinguish between rational fears and irrational and negative stereotypes which could be diffused or eliminated by procedural safeguards and education programmes.

Secondly, the findings of the selected studies serve as a reference point for the findings of this study - whether they will confirm, refute or add to previous findings as well as highlighting areas for future research. Thirdly, from a methodological standpoint, via their research questions, approach, problems encountered and what eventually was achieved, these studies serve as an important reference point when designing the research tools in this study and carrying out the fieldwork, which is the subject of Chapter 4.

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## C H A P T E R 4

### METHODOLOGY

#### INTRODUCTION

In order to gain a 'total picture' of the 'universe' under study and to answer the research questions outlined in Chapter 1, it was necessary for the researcher to analyse secondary data and to collect her own data. She analysed the following sources of secondary data:

- (i) NETRHA's policy documents and feasibility studies on Friern closure, and responses to these.
- (ii) Reports and operational policies produced by IHA, LBI SSD, and the voluntary organisations involved in Islington's Friern closure programme - Islington MIND, Peter Bedford Trust ((PBT), and the Psychiatric Rehabilitation Association (PRA).
- (iii) Minutes of meetings concerned with Islington's Friern Closure Programme.
- (iv) Local newspaper accounts which referred specifically to Islington's Friern closure programme or to the hospital during the closure programme.

The findings of the analysis of the above sources of secondary data appear in Chapters 7 and 8, and some of the implications of these findings are included in Chapters 9, 10, and 11. The other findings presented in Chapters 7 - 11 come from primary data.

With reference to the six studies reviewed in depth in Chapter 3, this Chapter now discusses the methods the researcher adopted to collect her own data, the problems that were encountered, and what eventually was achieved.

### INITIAL CONTACT

The researcher's first contact was a member of TAPS, based at Friern Hospital, who supplied background information on Islington's Friern closure programme. He also advised that the successful execution of the research, given the focus on the selection of long-stay patients for residential projects in the community and their experience of life in the community, would largely depend on the initial cooperation of the Unit General Manager of Friern Hospital, LBI SSD's Friern Closure Programme Officer, and IHA's Clinical Psychologist.

### INTERVIEWS WITH 'KEY' PROFESSIONALS

The researcher compiled semi-structured interview schedules to be used with the above-mentioned 'key' professionals. The schedules were 'individualised' to enable her to find out about their particular role in, and experience of, Islington's Friern closure programme. These professionals were also asked for their opinions (personal and agency) on the following issues which she had highlighted as being important in the course of formulating her research questions.

(a) Patient assessments.

(b) The selection of patients for projects in the community, and whether patients would be able to choose their own placements.

(c) The work which had to be done with patients to prepare them for the move to the community.



(d) The nature and level of staff required in community projects.

(e) Whether the same medication would be required in the community.

(f) Public consultation exercises and how people in Islington were likely to react to ex-long-stay patients in their midst.

(g) Whether all long-stay patients would be reprovided for in Islington by the closure date of Friern.

(i) How the progress of ex-long-stay patients was being monitored, and the probability of them relapsing, requiring re-hospitalisation, and moving on to independent living.

The key professionals were also asked for their permission and/or assistance in gaining access to patients and ex-patients and groups which discussed them, to suggest the names of other professionals who should be consulted, and if there were any issues which they considered important which the researcher had omitted.

The individualised questions for the Unit General Manager tended to be hospital-based. He gave written permission to attend meetings and other activities within the hospital, as long as the agencies organising these had no objection.

The questions for LBI's Friern Closure Programme Officer tended to concentrate on planned and operational projects in Islington for long-stay patients. She arranged for the researcher to attend meetings of Project Groups which would be selecting long-stay patients for two residential projects managed by LBI's SSD (Adult Care and

Clerkenwell), if IHA agreed. She also arranged for her to attend presentations of planned projects for patients on the Islington wards, and a Residents Meeting which had been called to discuss a proposed residential project for psychogeriatrics in Islington (Aberdeen Road). She personally introduced the researcher to many other professionals involved in Islington's closure programme, which proved extremely beneficial when she approached them about being interviewed or interviewing ex-patients in their care.

The questions for IHA's Clinical Psychologist tended to be patient and ex-patient centred. After a discussion about the research questions, the approach to be adopted, and some ethical issues, he agreed that the researcher could attend the Adult Care and Clerkenwell Project Groups, and also approach the Managers of residential projects in Islington with regard to interviewing their ex-patients. He also drew her attention to some practical considerations which should be borne in mind when interviewing ex-patients, for example, that people suffering from schizophrenia generally had very short attention spans so the interviews may have to be carried out in two or more sessions.

In accordance with the guide-lines for conducting semi-structured informal interviews which were discussed in *Appendix 2.1*, all the questions in the interview schedules were open, and the researcher allowed the respondents to move on naturally to prepared questions, and to introduce additional topics. Long replies were recorded in shorthand which allowed her to capture exactly what was said, and

respondents were asked to inform her if there was anything on which they did not wish to be quoted. The interviews lasted approximately one hour. They were written-up immediately afterwards, and particular areas of interest that had emerged and required further investigation were highlighted.

#### INTERVIEWS WITH OTHER PROFESSIONALS

The researcher then contacted the wide range of professionals in voluntary and statutory organisations (hospital and community-based), mentioned by the 'key' professionals. She outlined the nature and purpose of the research, and requested a one hour interview - all readily agreed.

This second group of professionals to be interviewed were predominantly representatives of the managing agents (IHA, LBI's SSD, MIND, PBT, and PRA) of the residential projects which long-stay patients had moved to or would be moving to in Islington, and three Teams who were directly involved with long-stay patients and ex-long-stay patients - the LBI SSD's Friern Social Work Team (SWT), IHA's Transitional Team (TT) based at the hospital, and IHA's Community Mental Health Resource Team (CMHRT) based in Islington. These Teams will be discussed in detail in Chapter 8.

She adopted the same approach used with the key professionals to interviews with these professionals. However, they were also asked to comment on their relationship with other professionals/agencies and, in the

writing-up, issues on which there seemed to be conflict between them were also highlighted.

This second group of professionals referred her to additional professionals to contact on specific issues, for example, on particular Day Centres. One issue which emerged as being more important than the researcher had anticipated concerned the role and experience of nursing staff in Islington's Friern closure programme, and this prompted her to interview nursing staff and those involved with their employment. She adopted the same approach to all these interviews, but professionals contacted about a specific subject were not asked to comment in detail on wider issues. However, some did have, and offer, their opinions on these issues.

#### COMMENTS ON INTERVIEWS WITH PROFESSIONALS

A list of all the professionals interviewed is contained in *Appendix 4.1*. The researcher found the replies given by these professionals to be extremely detailed and frank. They seemed to welcome the opportunity to talk about particular problems they had experienced and areas of the closure programme which were causing them concern.

Only one person who initially agreed to be interviewed was not actually interviewed - the Confederation of Health Services Employees' (COHSE) representative at Friern Hospital. After two aborted meetings, the researcher wrote asking him to reply to her questions in writing, and in confidence, but he did not reply. Some of these questions referred to a very controversial area - allegations that

some nursing staff had either refused to cooperate in matters relating to the hospital closure programme, or had effectively sabotaged the move of some patients to the community.

The structure of interviews with professionals can be likened to a Family Tree. At the top, the 'key' professionals who directed the researcher to other professionals, and so on, with branches both intertwining and extending to people with experience of specific areas. At the outset, she had very scant information on the 'universe' under study, but as the number of interviews increased, and with them the number of questions to be answered, her knowledge and understanding of the situation gradually grew.

Given the focus on the experience of ex-long-stay patients and community attitudes outlined in Chapters 1 and 3, the researcher had not anticipated interviewing so many professionals (26 individuals and 5 in a group situation). Therefore, it was the research process itself which dictated how certain aspects of the study developed.

She was able to keep track of developments from a professional perspective from the minutes of meetings of the Progress Review Group, which discussed the progress of Islington's Friern closure programme, and of the Rehabilitation Task Force, which was concerned with issues affecting patients and ex-patients in Islington's closure programme, for a period of two years. These two groups are referred to further in Chapter 8.

She was also able to continually observe how some of the professionals she had interviewed interacted with each other and listen to any problems they were experiencing in the fairly regular contact she had with them at Project Group Meetings for Adult Care and Clerkenwell.

#### ATTENDANCE AT PROJECT GROUP MEETINGS

Each residential project for non-psychogeriatrics had a Project Group which selected patients for that particular project. Projects for psychogeriatrics did not have Project Groups because it was unknown until the project was about to become operational who would be moving there, because of the high turnover of this group of patients due to death.

The researcher could locate no standard Terms of Reference for, or composition of, the Project Groups but, according to IHA's Clinical Psychologist, they were attended by eight or nine people representing the owners of the property, the managers of the project, and hospital and community-based staff employed by IHA and LBI SSD. The Project Groups met monthly at Friern Hospital to discuss an initial list of patients believed to be suitable for the project and finally exclude those considered unsuitable. They then discussed individual cases, planned individual programmes around the skills required with Ward Teams, and reviewed their progress.

The researcher attended meetings of the Adult Care and Clerkenwell Project Groups in Fellowship House, for 15 months from their inception, as an 'overt observer'. At the first meeting of each Group, she gave a brief outline of the

nature and purpose of her research and explained her intention to 'observe' these meetings to find out how patients were selected for projects in the community and prepared for the move. She did not want to participate in these meetings since this might interfere with the normal workings of the Groups. She hoped that the detachment afforded to the role of 'observer' would make it possible to give an objective view of the proceedings.

However, at the first meeting of the Clerkenwell Project Group she discovered that even a simple enquiry could constitute 'interference'. She had been led to believe that a member of a Users Group would be attending the meetings, representing patients. The members introduced themselves very quickly and she thought she had missed the name of the person from the Users Group. When she asked who this person was, she was told that patients were not represented, but the Group then discussed whether or not the patients should be represented. They eventually decided against patient representation so the researcher's question did not cause them to deviate from their original intention.

While occupying the role of 'observer' at the Project Groups, she intended to pay particular attention to the use made of Patients Assessments, any references made to the life of patients pre-hospital, the language used by different professionals to describe patients, any conflicts between professionals on selections, the characteristics of patients which precluded them from being selected, any mention of how patients themselves felt about projects, what sort of work would need to be done with patients to prepare

them for the move, who would carry this out and how their progress in the community would be monitored. She would also note how the actual work of the Project Groups compared with their original aims and operational definitions.

She took her own minutes of these meetings, noting some statements made by members of the Groups in shorthand to capture exactly what was said. These were written-up as soon as possible afterwards. She highlighted important points and noted her interpretation of the tone of the meetings, with reference to non-verbal forms of communication during the meetings, and conversations which took place before and after the meetings. She later compared her own minutes with the 'official' version, noting any differences.

She encountered a number of problems in the course of attending these meetings. She found it extremely difficult not to offer her opinion when there were conflicts between professionals on the suitability of patients for projects especially when she agreed with those who needed support to 'win' their case. She also found it difficult not to respond to facial expressions made in her direction by members of the groups to comments made by other members especially when she agreed with them.

On many occasions, she wanted to ask questions about patients and make points about their suitability for projects which were not raised by the group. She also often wanted to refer members to previous meetings when they had agreed to carry out tasks or discuss issues which they later seemed to have forgotten or disregarded.



She found many differences between her minutes of meetings and the official versions, especially with regard to the list of patients being considered. However, she was unable to ask, for example, why names appeared on the official version that she had not heard being discussed, and vice-versa.

The dilemmas described above are all associated with the difficulty of adhering to the role of 'observer' which is a common problem in social science research. It was particularly problematic for the researcher because she had had to develop and sustain a level of rapport with most members of these groups in order to secure their cooperation in other aspects of her research, and this had involved 'interacting' with them. However, as an 'observer' at these meetings, she then had to suspend these interactions to avoid participating or interfering in any way. The conflict between the 'interactor' and 'observer' roles was especially difficult to resolve when she was asked for her opinion on the proceedings of meetings, outside the meetings.

The researcher became more aware of her own attitude to patients while attending these meetings, since she increasingly experienced a sense of annoyance when they were described in purely medical terms, and when their feelings about hospital closure and moving to projects in the community were given little consideration, especially since they were 'unrepresented' at the Project Groups. She, therefore, welcomed the opportunity to have some direct contact with patients and ex-patients.

### PARTICIPATION IN WARD PRESENTATIONS

The researcher took part in Ward Presentations on three residential projects managed by LBI's SSD (Clerkenwell, Adult Care, Hornsey Lane), day care facilities, and work schemes in Islington on four Islington wards of Friern Hospital (Ward 2 - male, Ward 5 - mixed, Ward 17 - female, Ward 15 - male), over a period of two months at the beginning of 1989. These presentations were organised by LBI SSD to give both nursing staff and patients information about them, and patients an opportunity to voice their opinions about living there.

The presentations were made by small groups of hospital and community-based professionals from statutory and voluntary organisations, and one ex-patient. Photographs and architects' plans were pinned-up on the wards, and short talks were given about different aspects of the projects. Patients and staff were then invited to ask questions or express their feelings about what they had seen and heard.

The researcher helped to arrange seating, pinned-up photographs, and encouraged patients to come and listen to what was being said. She was introduced as a researcher and, after the presentations, talked to patients and staff about their initial impressions of the projects. This gave her an opportunity to meet some of the patients who were being considered for Clerkenwell and Adult Care at the Project Group meetings she was 'observing'. She then attended a 'Grand Presentation' of all the projects in the Main Hall, where she was again able to mingle and talk with

patients, nursing staff, and other professionals about the projects.

Meeting patients at these presentations and other visits to the hospital, served as an 'opener' when she came to interview some of them in the community. She was not aware of any other 'gatherings' on the Islington wards of Friern which gave patients information about projects and encouraged them to express their opinions, during the two years that she was making regular visits to the hospital.

#### ATTENDANCE AT A MEETING OF THE ISLINGTON MENTAL HEALTH FORUM

The researcher attended one meeting of the Islington Mental Health Forum (IMHF), a Users Group, which met monthly in Islington. The Forum was set up by patients and ex-patients as a platform from which to air their views about the planning and running of mental health services, and the Chairperson had been involved in the planning process for the closure of Friern Hospital.

She had wanted to attend the Forum as an 'observer' to hear the views of Friern long-stay patients still in the hospital, and those who had already moved to Islington. The people attending the Forum, however, were either ex-Friern short-stay patients or ex-patients of other hospitals, who were using the Forum for support and for formulating ideas for improving services. Also, most of the Forum's meetings were for users only, although selected professionals from agencies involved in mental health service provision were invited to attend meetings periodically to comment, on behalf of their agencies, on a particular issue.

The subject of the meeting she attended was Section 136 of the Mental Health Act (1983), and users gave harrowing accounts of incidents in which they had been the subject of wrongful treatment, for example, in being taken to hospital, kept in, and given Electro-Convulsive Therapy (ECT) against their will. Since she felt 'inadequate' because she was not able to comment on these accounts on behalf of any of the agencies the users had targeted to respond, and because the Forum was not, at that time, catering for the people who would be the 'subjects' of her research, she did not attend any further meetings of the Forum.

#### INTERVIEWS WITH EX-LONG-STAY PATIENTS AND THEIR 'CARERS'

##### The People To Be Interviewed

The researcher wanted to interview people who had been long-stay patients on the Islington wards of Friern, and who had been transferred to the community as a result of the hospital's closure programme, about their experience of the move and of life in the community. She called these people 'ex-long-stay patients' to distinguish them from other 'ex-patients', that is people living in Islington who had been Friern short-stay patients and, therefore, not part of the closure programme and also long-stay patients discharged before the closure programme began. By referring to all these people as some form of 'patient', she, like Jones (1985)<sup>1</sup>, was not implying adherence to the medical model - these terms were being used merely for ease of identification and differentiation (p4).

She compiled a list of residential projects for Friern ex-long-stay patients in Islington, in the order that they had become, or were expected to become, operational - see *Appendix 4.2* for projects for non-psychogeriatrics and *Appendix 4.3* for projects for psychogeriatrics.

She decided not to interview psychogeriatrics because Jones (1985)<sup>1</sup> had found that many patients in the elderly confused group were unable to make responses (p72), and Islington professionals reported that psychogeriatrics would be difficult to interview due to the nature of their illness (dementia and physical frailty), and also that their care would predominantly be care in the community.

She initially wanted to interview all the ex-long-stay patients living in the first four projects for non-psychogeriatrics (Adult Care managed by LBI' SSD, Isledon & Arthur Roads managed by PBT, Shaftesbury Road managed by Islington MIND, Cloudesley Road managed by PRA), who would agree to be interviewed, not a sample. Therefore, the ex-long-stay patients would be self-selecting.

She noted that these four projects for the 'first movers' tended to cater for people requiring a lower level of support, that three of them were managed by voluntary organisations, and that only one person in Adult Care was actually living in Islington.

Following Jones (1985)<sup>1</sup>, she wanted to supplement or cross-check the accounts of ex-long-stay patients (p72) by interviewing someone who, ideally, had known them before they left hospital, and since they had been living in the

community. She envisaged this person as being an immediate 'carer' in the community.

### The Approach To Be Adopted

All the people living in the first four projects were part of the TAPS follow-up study and were, therefore, already being 'objectively' studied. The researcher anticipated that this may affect the outcome of her research, that is, that some ex-long-stay patients may not agree to be interviewed because they had been 'over-researched'.

Given the vulnerability of people with mental health problems, and that the aim of the research, following Birch (1983)<sup>2</sup>, was to allow the 'subjects' of the research an opportunity to 'speak for themselves' (p1), she believed, like Jones (1985)<sup>1</sup>, that formal questionnaires would be off-putting and inappropriate (p72). However, non-directive informal interviews would be both impractical and inadequate because of the range of topics she wanted to cover, and the anticipated short attention span and disability of ex-long-stay patients, with regard to communication, as a result of their illness, the side-effects of medication and other treatment, and their long-term institutionalisation.

She, therefore, decided to conduct interviews with ex-long-stay patients using a semi-structured interview schedule, listing questions under a number of discrete headings but adopting, as far as possible, like Goldie (1988)<sup>3</sup>, a conversational approach (p14). Questions would be open to give people an opportunity to expand on their replies, and the researcher would allow them to move

naturally to other questions and to introduce new topics. She would not use tape-recorders as, like Jones (1985)<sup>1</sup>, she believed they would be inhibiting (p72). As with the interviews with professionals, she would note longer replies in shorthand to record exactly what was said.

Carers would be asked to give their opinion of the experience of the ex-long-stay patients with whom they were acquainted, also using a semi-structured interview schedule which covered the same subjects as the ex-long-stay patients had been questioned about, and the same approach.

She would write-up interviews immediately afterwards, and highlight and comment upon important issues which had arisen. Following Birch<sup>2</sup> (1983), she would also note the way she felt about the interview in general, and the response to herself and the questions, to give context and meaning to the written reproduction of the interview (p12).

Drawing on a finding of Goldie's (1988)<sup>3</sup> study, that the more recently discharged patients were less likely to agree to be interviewed because they feared the outcome (p88), she decided to interview ex-long-stay patients in the order that they had left the hospital. She would ask Managers of the projects to supply the following 'standard' information for people who did not agree to be interviewed: sex; age; marital status; ethnic origin; clinical diagnosis; length of stay in Friern; length of stay in the project; and, any reason given, or known about, for declining to be interviewed. This would help her to ascertain whether or not the people interviewed were 'representative' of all

those living in the first four projects and all the long-stay patients in the closure programme.

### The Draft Interview Schedules

Following Goldie (1988)<sup>3</sup>, the researcher decided not to seek to scale or measure 'quality of life' (p26), but found it useful to refer to Jones (1988)<sup>1</sup> 'Profile of Quality of Life Criteria' (Appendix 2, p72-75), as well as Goldie's questions (Appendix 2, p93-97), when drafting her own interview schedule for ex-long-stay patients. She envisaged the interview as progressing from questions about the project they were living in, moving outwards to the community and contacts, and then looking back to life in the hospital. She thought that leaving questions about the hospital until the end would be less anxiety-provoking for those who might be afraid that her research had something to do with returning them to the hospital, even though she would have attempted to allay this fear.

Consequently, the first draft of the interview schedule for ex-long-stay patients was divided into five sections in the following order: Personal Details; Domestic Life; Community Life & Contacts; Daily Life; and, The Hospital. The first draft of the interview schedule for their carers asked for their opinion of the life of ex-patients, pre-hospital, in hospital, and in the community.

These first drafts were given to the researcher's supervisor and a member of TAPS for their comments. As a result, some amendments were made to particular questions, changes were made to the subject and question order, and



additional questions were included in the schedule for ex-long-stay patients. This was now divided into seven sections in the following order: Domestic Life; Community Life; Daily Life; Contacts; Finances; the Hospital; and, Personal Details. It had been pointed out to the researcher that their immediate carers in the community may have only scant and second-hand knowledge of their life in the hospital or pre-hospital. She, therefore, decided to construct two interview schedules from the original version intended for carers - one to be used with adult carers/workers, and the other with someone who knew them in the hospital before the move, for example, a relative or member of hospital staff, and whom she would call a 'contact'.

She sent the second drafts of the interview schedules to IHA's CMHRT, TT, and Clinical Psychologist, LBI SSD's Friern Closure Programme Officer and Adult Care Officer (ACO), and a Research Methods Tutor. Their comments on the Schedules for ex-long-stay patients were invaluable. For example, she should include specific questions about Day Centres and Drop-Ins, give examples of the sort of professionals these people were likely to be in contact with on a regular basis, and re-word some questions to make them more personal and individual. Only very slight changes to the wording of questions in the schedules for adult carers/workers and contacts were suggested.

She asked the Chairperson of the IMHF to comment on the third version of the schedule for ex-long-stay patients, and the approach she intended to adopt because she wanted to avoid, wherever possible, any questions which may seem

insensitive. He approved of the approach and did not think that any of the questions, in themselves, would cause distress. He did feel, however, that when approaching the ex-long-stay patients about being interviewed it was important to emphasise that she was in no way connected with the hospital or any of the agencies involved in the closure programme. This would mean that they would not be so worried about the repercussions of talking to her, for example, that they were being 'tricked' back into hospital. Also, it would be patients and ex-patients who would benefit from the research.

He also said that she should be aware that it might be stressful for some people to remember things, therefore, she should not push them, but be prepared to conduct the interviews over two sessions.

### The Pilot Study

The main purpose of the Pilot Study was to 'try out' the interview schedules for ex-long-stay patients, because the focus of the research was their experience, and it was this schedule which had evoked the majority of comments. The researcher did not anticipate having any serious problems with the schedules for adult carers/workers and contacts.

In conducting the Pilot Study, she was most interested to find out the answers to the following questions:

- (a) What proportion of the ex-long-stay patients approached would agree to be interviewed?
- (b) How long would the interviews take?

(c) Were there any sections ex-long-stay patients were reluctant to tackle, and were there any questions they did not understand, or did not want to answer?

(d) Were there any issues that she had not anticipated?

(e) Would it be possible to identify a 'contact' from the interviews with ex-long-stay patients?

For the Pilot Study, she wanted to find a residential project for ex-Friern long-stay patients in a borough other than Islington. Of the non-Islington projects which were part of the Friern closure programme, the Group Home in Hilldrop Road, which was a joint undertaking by Hampstead Health Authority and the London Borough of Camden seemed suitable for a number of reasons. It had only been operational for eight months so the people living there had not yet been 'followed-up' by TAPS and they were not the subject of any other research. They should, therefore, not have any preconceived ideas about researchers, and they had not been 'over-researched'.

As a Group Home, it was the same 'type' of project as three of the first four residential projects in Islington. Also, it was managed by the London Borough of Camden's Social Services Department whose philosophy on the care and management of the mentally ill in the community was likely to be similar to at least two of the managing agents of the first four Islington projects.

The project in Hilldrop Road was intended to be a home for nine non-elderly men and women, two of whom would be from minority ethnic groups. These residents, therefore, should be 'representative' of the people the researcher

wanted to interview in Islington with regard to sex, age, gender, and ethnic origin. With 24 hour (non-nursing) care, it had a higher level of support than the majority of the first Islington projects which, coupled with the short time it had been operational, would probably mean that the residents were likely to be less able and confident than the people living in the first Islington projects. They may, therefore, be more difficult to interview, thus providing a challenge.

On the researcher's first visit to the Group Home, the Head of House and another worker supplied her with background and current information on the project. A description of the Group Home in Hilddrop Road, its Staff and Residents, derived from this informal interview and the her observations, appears in *Appendix 4.4*. The project workers also mentioned that local GPs had refused to accept the residents, and eventually the Association of Family Practitioners had to intervene. As a result, there was not a healthy working relationship between the project staff and the GP who had been forced to take responsibility for the residents.

The project workers also reported that cigarette-smoking had been a serious problem when the project first became operational because the residents had been accustomed to stubbing-out cigarettes on the floor in hospital where they could be easily swept up. However, in the Group Home, this practice ruined carpets and constituted a fire risk, so residents had to be continually reminded to use an ash-tray.

Further, there were so many 'eccentric' people living in the area that their residents could go about unnoticed.

The project workers were happy about the questions she wanted to ask their residents and her approach, but were not optimistic about the response in general, that is in agreeing to be interviewed, or on specific subjects, for example, they said their residents had little experience of Day Centres so were unlikely to have much to say about them.

The comments of these workers led her to design a front sheet for the interview schedule for ex-long-stay patients which contained a list of the different sections in the interview, as well as the personal details required. This meant that she could read them to the ex-long-stay patients at the beginning of the interview and offer them the opportunity to choose the sections they wanted to start with. She could then tick-off sections as they were completed and if interviews went on over a few sessions, she would be able to see 'at a glance' the sections which were outstanding.

The Group Home at Hilldrop Road had opened in April 1989 and by November, when the researcher first visited, six people had moved in. Two of them had returned to Friern Hospital although it was hoped that one would be able to come back to the project in the near future. Three other people had been selected for the project - one was visiting with a view to moving in, and two were being prepared for the move in the hospital. Therefore, there were four people currently living in the project. They were:

Sex:	Male	Male	Female	Female
Age:	58	47	38	65
Marital Status:	Single	Single	Single	Divorced
Ethnic Origin:	Irish	White UK	White UK	White UK
Time in Friern:	37 yrs	29 yrs	19 yrs	4 yrs
Time in Project:	8 mths	7 mths	8 mths	8 mths

On a tour of the house on her first visit, she had met three of these people and briefly mentioned the research. The project workers felt that the best way to approach them about being interviewed was through their 'keyworkers'. The keyworkers duly spoke to their residents - the two males agreed to participate and two females said 'maybe'.

The keyworkers felt that it would be useless to arrange specific times to interview the residents as there was no guarantee that they would 'feel like it' at that time. Instead, the researcher arranged to telephone the house at times when all the residents were likely to be there, and if any of the residents wanted to be interviewed at that time, she would visit the house. On a couple of occasions, there had been a 'change of mind' by the time she arrived and, in the four weeks she had allocated to complete the Pilot Study, she was only able to interview the two male residents. She gave them fictional names, to protect their anonymity - the 58 year old male was called Douglas and the 47 year old male was called James.

Both Douglas and James seemed very nervous at the beginning of the interview, but once the researcher had assured them of the confidentiality of their replies, and offered them a cigarette (which the workers had advised her to do), they seemed to relax. Douglas was interviewed in one session and James was interviewed over two sessions. Both interviews lasted approximately 45 minutes.

There were no sections which they were reluctant to tackle, or questions which they had difficulty understanding or did not want to answer. However there were, as predicted, some subjects which they had little or no experience of and were unable to respond to, and the questions about professional contacts proved arduous in practice. Both Douglas and James said things that were confusing and, even after probing, she was still unclear what they meant. Also, she was unable to identify a 'contact' from their accounts so would not be able to 'try out' the schedule for contacts.

She felt that the interviews went well and that Douglas and James had some very interesting and, to her, unexpected points to make about their experience of moving from the hospital to the community. She also felt that it may have been possible to interview the two female residents, who had both been very disturbed while she was visiting the house, if she had not had a deadline for the completion of the Pilot Study.

The Head of House told her that he had not expected such a good response, in terms of the number of residents that agreed to be interviewed and the fact that they had

completed the interviews. He also mentioned that Douglas and James had seemed surprised that someone was interested in what they thought and felt about their experience. The Head of House, therefore, regarded the research as a positive exercise and hoped it would encourage residents to 'speak up' at their Residents Meetings.

She asked the keyworkers for Douglas and James to participate in the Pilot Study to 'try out' the interview schedule for adult carers/workers. The keyworker for Douglas was formerly a domestic support worker in the Group Home and had been working there since the project opened. She had become his keyworker because he had felt an affinity towards her because of their shared 'ethnic' origin (Irish). The keyworker for James came from an Agency and had only been his keyworker for six weeks.

Both keyworkers agreed to be interviewed and their interviews lasted approximately 45 minutes each. The researcher did not have any problems with the schedule and she noted that, although the keyworkers had not known Douglas and James before they came to the project, they had some second-hand information about their lives pre-hospital and during their long time in hospital.

The methodological implications of the Pilot Study were:

(a) From the level of support in the Islington residential projects and the length of time they had been operational, the researcher expected the Islington ex-long-stay patients to be more capable of, and confident about participating in the research than those who were the subject of the Pilot



Study. Also, there would not be such a stringent deadline on conducting interviews with Islington ex-long-stay patients. However, since they were all part of the TAPS follow-up study, they may be subject to the negative effect of 'over-researching'. She, therefore, predicted that at least 50% of the Islington ex-long-stay patients would agree to be interviewed.

(b) She retained the frontsheet for the interview schedule for ex-long-stay patients, and GPs were added to the list of professional contacts. She would, where possible, use her knowledge of professionals involved with ex-long-stay patients in Islington to personalise questions on these contacts, by referring to them by name rather than title.

(c) She amalgamated the interview schedules for adult carers/workers and contacts, and designed a frontsheet for the new combined schedule to distinguish between adult carers, workers, and contacts. From the interviews with ex-long-stay patients, she would choose the person she felt would be best able to give their opinion on different stages in the lives of ex-long-stay patients and with whom they seemed to have a good relationship. She expected this person to be their immediate carer or keyworker in the community and the category of 'contact' was intended as a safeguard for anyone who admitted not liking this person or if this person did not agree to be interviewed. She anticipated these 'contacts' as being psychiatrists, social workers, members of hospital or community-based teams, nurses, or relatives. She also added a section to this new schedule entitled 'Points for Clarification' on which she

could list any confusing or ambiguous statements made by ex-long-stay patients and discuss them with their adult carers/workers/contacts.

(d) She added a question to both interview schedules which allowed the respondents to introduce any subjects which they felt were important but which she had not mentioned.

(e) She would allocate one hour to the interviews with ex-long-stay patients and their adult carers/workers/ contacts and be prepared to conduct the former over two sessions.

The final versions of interview schedules for ex-long-stay patients and adult carers/workers/contacts appear in *Appendices 4.5 and 4.6*, respectively. The other 'findings' of the Pilot Study are the subject of Chapter 9.

#### The Number of Ex-Long-Stay Patients To Be Interviewed

According to the researcher's records, there were 30 ex-long-stay patients living in Islington's first four residential projects (see *Appendix 4.2*) - Adult Care (LBI SSD), Isledon & Arthur Roads (PBT), Shaftesbury Road (MIND), and Cloudesley Road (PRA). From the Pilot Study, she expected at least 15 to agree to be interviewed. To increase the number of ex-long-stay patients in the study and add to its validity, she had intended to follow a group of patients out of the hospital, interviewing them before they left concerning their feelings about the hospital and their expectations of life in the community, then after they had moved about the reality of life in the community and whether their feelings about the hospital had changed.

The next residential project expected to become operational was Clerkenwell which was managed by LBI's SSD (see *Appendix 4.2*). Also, LBI SSD anticipated placing up to nine more people in Adult Care, in Islington or within a quarter mile radius of the borough. By including the people moving to Clerkenwell and the 'new movers' to Adult Care in the study, she would potentially be increasing the number of ex-long-stay patients in the study by 18 people whom she would be able to interview before TAPS and who would, consequently, not have been 'over-researched'.

The Adult Care and Clerkenwell Project Groups agreed that when patients had been selected as candidates for these projects, she could join in the preparatory work. This would give her the opportunity to get to know these people which would, hopefully, lead to a better response, both in securing their agreement to be interviewed and in the 'quality' of their replies.

In practice, she was unable to carry out this 'Before/After' part of the research. In the 15 months she had attended meetings of the Adult Care Project Group, not one person was selected. With regard to the Clerkenwell project, the arrangement she had made with the CMHRT, to join in the group preparatory work for the move, did not come to fruition because the TT did not hand the patients over to them for this work to be carried out. Preparatory work was largely hospital-based, carried out by members of the TT and the Friern SWT on an individual basis, and the times arranged for this work were continually changing.

As a result of the above, she decided to interview people who eventually moved to Clerkenwell in the same way as those already living in the community. Since the Cornwallis project managed by IHA (See *Appendix 4.2*) was due to become operational at the same time as the Clerkenwell project, which had been delayed six months (reason discussed in Chapter 8), she decided to add it to the research programme to compensate, in terms of numbers, for the fact that there had been no 'new movers' to Adult Care. Thus, according to her records, she should be able to approach 48 Islington ex-long-stay patients about participating in the research.

#### Approaching the Ex-Long-Stay Patients

In the course of interviewing the representatives of the managing agents of the residential projects and obtaining background information on the projects, the researcher asked for their cooperation in gaining access to the ex-long-stay patients living in their projects. They had no objection to the type of questions she intended to ask or her approach and they all agreed, in principle, to assist her in making initial contact with their residents to find out if they would be willing to participate. They did mention, however, that their residents, who were part of the TAPS follow-up study, were already complaining about 'continual questioning'. They were, therefore, concerned about protecting the privacy of their residents.

LBI SSD's ACOs had drawn her attention to the fact that, although the aims of her research were commendable,

the ex-long-stay patients would have to 'give-up' their time to participate. Also, the Clerkenwell Project Manager said, 'we have hundreds of researchers from all over the world knocking at our door, so now we only let them in if the residents can get something out of it'.

Since these mirrored the comments made to Birch (1983)<sup>2</sup> by the hospital who refused to take part in her study (p7), she concluded that it seemed unreasonable to expect the Islington ex-long-stay patients to see the immediate benefits of her research to themselves, or others, and to freely give up their time to participate. She, therefore, decided to give five pounds to each ex-long-stay patient who was interviewed, to compensate them for time that could have been spent doing other things. This may be regarded as coercing the participants in that it is offering an incentive (money) to people whom the researcher expected to be very poor. Since she hoped that her research would ultimately benefit Friern ex-long-stay patients and patients and ex-patients of similar hospitals, and that it would be meaningless without the cooperation of the Islington ex-long-stay-patients, this seemed justified.

Given the possibility of ex-long-stay patients suffering 'relapses', she decided to first consult the project managers to find out if all the people living in their project were well enough to be interviewed. Then she, ideally, wanted to be given the opportunity to meet the ex-long-stay patients so that she could personally tell them about her research and ask them if they would be willing to be interviewed.

If this was possible, she would stress that she was independent of Friern Hospital and all the agencies involved in the closure programme, the interviews would not be taped and their replies would be confidential. Also, the interviews would be as informal as possible, they would take place at times and in a place of their choosing, they would be able to choose the order of questions in the interview, and they would not have to answer any questions they were unhappy about. Further, the research could benefit not only those in the Friern closure programme, but also people in other similar hospitals which were scheduled to close. Finally, those who were interviewed would be given the sum of five pounds.

She accepted that some project managers may prefer to first broach the subject of participating in the research with their residents, themselves, in an effort to protect their privacy. In this event, she would ask them to stress the above-mentioned points.

She thought that some ex-long-stay patients may want to be interviewed at their Day Centre, and a list of Centres and Drop-Ins in Islington for Non-Psychogeriatrics is contained in *Appendix 4.7*. She anticipated that most of the 'first movers' would be attending LBI Day Centres because they had been established for the longest time. However, due to understaffing at these Centres, which will be discussed in Chapter 8, she decided that those who wished to be interviewed at their Day Centre should be left until the end of the research period and interviewed 'en bloc', centre by centre, so as not to abuse the 'goodwill' of Day Centre

staff. Those whom she was unable to interview first time round because of illness, and those who had left their initial placement, would also be approached at the end of the research period. She did not anticipate having any problems tracing the Islington ex-long-stay patients, which was a difficulty expressed by both Jones (1985), p71<sup>1</sup> and Goldie (1988), p14<sup>3</sup>.

A detailed description of the process of approaching long-stay patients who had moved to Adult Care (LBI's SSD), Isledon & Arthur Roads (PBT), Shaftesbury Road (MIND), Cloudesley Road (PRA), Clerkenwell (LBI's SSD), Cornwallis (IHA), and Hanley Road (IHA) about participating in the research, the problems that were encountered, and the eventual outcome, is contained in *Appendices 4.8* to *4.14*. The following sections summarise this process.

It will have been noted that Hanley Road (see *Appendix 4.2*) was not part of the original interview programme. This was because the researcher had not anticipated that it would be operational until six months after the final date she had originally fixed for interviewing ex-long-stay patients. However, due to the length of time taken to approach people living in other projects, the small number that were 'agreeing' to be interviewed, and other problems which the following sections will discuss, she had to extend the final date by nine months. Also, the discovery that the Cornwallis and Hanley Road projects shared a Residential Services Manager (RSM) suggested that it would be possible to approach the residents of these projects at the same time.

The addition of the Hanley Road project to the research programme was, in theory, increasing the anticipated number of ex-long-stay patients who could be approached about being interviewed by 24 to 62.

The Number of Ex-Long-Stay Patients who could be Interviewed

Eleven people had moved to Adult Care. However, only seven could be asked to participate because one had returned to hospital and was too ill to be interviewed, two could not be interviewed because of hearing and speech problems, and one had left her placement, whereabouts uncertain - a letter to her last known address producing no reply.

There were only four people in the PBT project because one resident had recently died, and there was one long-term vacancy because of the low-level of support in the project. Five of the original six people were still living in the MIND project and one had moved on to independent living, however, he could be contacted. There were the anticipated seven people living in the PRA project, but only seven in Clerkenwell because two had returned to hospital. There were also only seven people in Cornwallis, because the other two were still preparing to move in.

At the Hanley Road project, there were six people living in each of the four houses. However, due to the lack of information on particular residents, it was not possible to predict how many would be able to be approached about being interviewed.

Therefore, of the original 48 ex-long-stay patients which the researcher had anticipated it would be possible to



approach about being interviewed, in practice, there were only 38.

#### Approaching the Ex-Long-Stay Patients

As discussed in detail in *Appendices 4.8 - 4.14* the researcher was not given the opportunity of personally speaking to ex-long-stay patients in Adult Care, Isledon & Arthur Roads, Shaftesbury Road, Cornwallis and Hanley Road about being interviewed. She had to rely on their Adult Carers, ACOs, members of the Friern SWT, Housing Support Workers (HSW), Project Managers and House Managers (HM) to broach the subject on her behalf. However, she was also allowed to write a standard letter to the residents and ex-resident of Shaftesbury Road and to the residents of the Cornwallis project via Project Managers.

A HM at Hanley Road brought up the issue of participating in the research at a Residents Meeting. and distributed standard letters to the residents. However, he did not know if his colleagues had followed-up the letters with their residents.

The researcher found Adult Carers to be uncooperative, even obstructive, with regard to helping both her and the ACOs to make contact with the people in their care. As Chapter 8 will show, Carers were paid to provide certain facilities and support to the people in their care and expected to encourage them to forge links with the wider community. In the absence of any systematic monitoring system which gave the people living in Adult Care the opportunity to express any grievance they may have with the

quality of their care, the researcher, therefore, concluded that this lack of cooperation was serious because it may indicate that Carers had 'something to hide'.

It was due to two changes in staff occupying the Senior HSW post at PBT, that she lost the rapport built up with the original person in this post and, consequently, the opportunity to personally meet people living at Isledon & Arthur Roads.

PRA refused the researcher any access to their residents. This change in attitude appeared to have been caused by PRA's perceived association between research (the project was part of the TAPS study and another PhD research), and criticisms of their management of the project made by IHA, which is discussed in Chapter 8.

Since she believed that PRA did not have the right to deny their residents the opportunity to participate in the research, she first asked two members of the CMHRT to approach the people living in the project about the research. They agreed, but later the Head of this Team felt that this would compromise their position with PRA. The researcher, therefore, decided to write directly to the residents at Cloudesley Road. She did not receive any replies but, in view of PRA's attitude, could not be certain that the residents had actually received her letters, since members of the CMHRT had led her to expect at least one positive reply.

She received up-to-date information on the Day Centres and Workshops attended by five of the seven residents of Cloudesley Road from the CMHRT - the other two residents did

not take part in any organised day-time activities. She then wrote to the Managers of these facilities asking them to approach these people, on her behalf, about participating in the research. According to the CMHRT, three Cloudesley Road residents were attending a new Day Centre (Southwood Smith) managed by PRA, and once again, PRA asked to be excused from any involvement with the research.

According to the leader of the CMHRT, PRA were in breach of their contract by refusing the researcher access to their residents. However, the researcher decided not to officially complain to LBI's Officer in Charge of Registration about this because she felt that as she had sent letters to all the residents, PRA could say that they did not reply because they did not want to be interviewed. Also, she did not want to cause further tension between PRA and the statutory organisations involved in the Friern closure programme.

Due to the negative effect that being part of the TAPS study had appeared to have on the response of people in earlier projects, she decided to approach ex-long-stay patients in Clerkenwell about participating in the research, after they had been out of hospital for six months, but before the first year follow-up by TAPS. The Clerkenwell Manager was keen for the residents to take part in the research because they would get a 'much-needed' five pounds. He brought up the subject of participating in the research at the Residents Meeting, then keyworkers discussed the subject with individual residents.

The researcher had met some of the people living in Clerkenwell during her visits to the hospital. She first met them all in the project as a group and explained briefly the purpose of the research, what the interview would entail, and that the interviews with all residents would take place over two or three evenings. The five pounds for participating proved to be such an incentive that the order of the interviews had to be decided by drawing names out of a hat, and there were still disagreements between residents, and between staff and residents about who should be interviewed on the first evening.

Due to the length of time (4 months) it had taken her to receive the name and contact number for the RSM for the Cornwallis and Hanley Road Projects, despite repeated letters and telephone calls to IHA's Priority Services Unit, TAPS had begun following-up people in Cornwallis so she had lost the anticipated opportunity of approaching them before they were susceptible to the negative effect of over-researching.

#### The Outcome - People Interviewed

Eventually, the researcher had to accept that only one person in Adult Care had agreed to be interviewed. This was a person whose Carer had initially said she would not be able to participate, then that she did not want to be interviewed. However, when an ACO spoke to her personally, she readily agreed. She was interviewed at The Avenue Day Centre and her keyworker at this Centre was interviewed about her.

The researcher was informed that all four PBT residents had declined to be interviewed. Only one Shaftesbury Road resident replied, by telephone, that she was willing to be interviewed. She was duly interviewed at the house, followed by an interview with her former HSW who had since moved to PBT. The ex-resident of Shaftesbury Road also replied, in writing, saying that he was willing to be interviewed. He was interviewed in his own flat and the researcher eventually interviewed a member of the CMHRT about him.

One Cloudesley Road resident replied via his Workshop Manager that he did not want to be interviewed. Another agreed to be interviewed via The Avenue Day Centre Manager and was interviewed at this Centre. A Day Centre Worker was then interviewed about her.

All seven Clerkenwell residents agreed to be interviewed but only six were interviewed - the seventh 'disappeared' while the interview process was going on. All the residents were interviewed in the Group Home or adjoining Bedsit House. Keyworkers for all the residents agreed to be interviewed but, due to staff illness and holiday leave, only two keyworkers were interviewed. A Friern Consultant/Community Psychiatrist was later interviewed about the other four residents.

The researcher had to 'assume' that none of the residents of the Cornwallis and Hanley Road projects had agreed to be interviewed.

Therefore, only ten ex-long-stay patients who had been part of Islington's closure programme (out of a possible 38) and their carers/workers/contacts were finally interviewed.

#### Reason for Declining to be Interviewed

The researcher concluded that it was uncertain whether the six people in Adult Care who had declined to be interviewed via their carers had made this decision themselves, or whether it had been made for them, or influenced, by their Carers.

The majority of the people living in the first four projects had already been followed-up more than once by TAPS. The researcher concluded that, apart from 'blocking' by carers, the six people in Adult Care had declined to be interviewed because they had been 'over-researched'. This was also the main reason why the four people living in the PBT project refused, although they also objected to the TAPS' method of questioning. Since she was not given the opportunity to meet them, she could not personally assure them that her approach and focus were completely different from that of TAPS.

She concluded that four residents of Shaftesbury Road had also declined to participate because of 'over-researching' - they had become both 'adept at and fed up with' interviews because they were not only part of the TAPS research but also MIND's own evaluation. Over-researching was also given as the reason why the seven residents of Cornwallis declined to be interviewed, that is, 'they were fed up with researchers and they did not want to have

anything more to do with the hospital - they just wanted to be left alone now they were in the community'.

The RSM initially identified 'over-researching' as the reason why Hanley Road residents had to be 'protected from researchers to allow them to settle in properly'. However, these residents were not yet being followed-up by TAPS and neither the researcher nor HM knew of any other research interest in the project. Since both the RSM and HM had intimated that the five pounds for participating would be an incentive for some people, she finally concluded that the reason why she had to 'assume' that the residents of Hanley Road had declined to be interviewed was because their actual response to being asked to participate had not been actively sought.

She was uncertain whether the six residents of Cloudesley Road had actively or passively declined to be interviewed because they had been 'over-researched', because PRA were not in favour of them participating, or if both these factors contributed to their decision.

Evidence of the negative effect of over-researching can be found in the positive response to being interviewed shown by the ex-long-stay patients living in Clerkenwell. This appeared to have been because they had not yet been followed-up by TAPS when they were approached about participating. However, the fact that the researcher had met some of them before in hospital, that she was able to personally speak to them before the interviews began, and that the five pounds for participating was 'much-needed', must all have contributed to the positive response.

### The Outcome - Standard Information Received

ACOs, Carers, and members of the Friern SWT provided most of the required standard information on those who were unable or unwilling to be interviewed in Adult Care - for some, it was only known that they had been in Friern for more than one year. PBT workers supplied the standard information requested on their residents.

A MIND HSW eventually supplied some of the standard information requested on Shaftesbury Road residents - he said he knew only that they had been in Friern for more than one year, did not know their clinical diagnosis, and that it was up to residents to define their own ethnic origin. The researcher 'estimated' this origin from an interview with a former HSW, and MIND reports.

She had to compile standard information on the six people in Cloudesley Road from PRA Annual Reports, IHA records, and information supplied by TAPS, because of PRA's lack of cooperation. The standard information for the two people in the Clerkenwell project who had returned to hospital was compiled from the minutes of Clerkenwell Project Group Meetings, and the accounts of Project Workers.

The Cornwallis Manager supplied standard information on their residents. The researcher did not receive a reply to two letters and numerous telephone messages to the HMs of Hanley Road requesting standard information on their residents.



### Length of the process

The whole process of attempting to contact people living in Adult Care about being interviewed, conducting interviews and obtaining standard information took 15 months. The researcher concluded that the non-response of Carers to her initial approach, the inability of ACOs to make contact with the ex-long-stay patients living in their project and, staffing problems within the Friern SWT, which will be discussed in Chapter 8, were the main reasons why this process had been so lengthy.

In the case of Shaftesbury Road, this process was also lengthy - 10 months. She concluded that this was due to the time taken to receive an initial reply from the new HSW, obtain written permission from the ex-resident to interview a member of the CMHRT about him, arrange a time to interview the member of the CMHRT due to her illness and holiday leave, and receive the standard information from the HSW. The process of attempting to make contact with the people living in Cloudesley Road, conduct interviews and compile standard information was extremely lengthy (12 months), largely due to PRA's refusal to cooperate in any way with the execution of the research.

The fruitless process of attempting to contact ex-long-stay patients in the PBT project and obtain standard information took six months, largely due to staff changes at PBT. The Cornwallis process was also fruitless and more lengthy (nine months) due to the problem she had encountered in obtaining a contact number for the RSM from IHA, this Manager's uncooperative attitude which became slightly more

amenable on hearing of the five pounds for participation, and also this Manager's illness (six+ weeks on sick leave). This also largely explained why the same process at Hanley Road was so lengthy (eight months). However, the researcher also repeatedly experienced difficulties in getting the HMs to respond to her enquiries, and this process was particularly fruitless because no standard information on residents was received.

It took 10 months to approach and interview six people living in Clerkenwell and their carers/workers/contacts, and obtain standard information on those who had returned to hospital. The length of this process, unlike the others, was justified in terms of the number of interviews conducted albeit that a few months were 'wasted' waiting for times to interview the keyworkers of four of the residents, because these interviews never took place.

### The Final Outcome

The researcher had anticipated that there were 48 ex-long-stay patients living in Adult Care, Isledon & Arthur Roads, Shaftesbury Road, Cloudesley Road, Clerkenwell, and Cornwallis. In practice, she found that there were three long-term vacancies, one vacancy due to death, one person whose whereabouts were unknown, four people who had returned to hospital and were not well enough to be interviewed, and three people who could not be interviewed because of severe hearing and speech problems.

This meant that there were 38 ex-long-stay patients who could be interviewed. She found or had to assume that 28 of

these had declined to be interviewed. The reason given by, or on behalf of, the majority of ex-long-stay patients was 'over-researching', although in the case of Cloudesley Road residents, the negative attitude of PRA to research also played a part.

Therefore, only ten ex-long-stay patients agreed to be interviewed and were interviewed, followed by interviews with their carers/workers/contacts. Their experiences are the subject of Chapter 10, and the first five residential projects, in which all the ex-long-stay patients interviewed lived are discussed in Chapter 8. Standard information on the people living in Adult Care, Isledon & Arthur Roads, Shaftesbury Road, Cloudesley Road, Clerkenwell, and Cornwallis who were not interviewed appears in *Appendix 4.15*, project by project.

The researcher concluded that she had grossly underestimated the negative effect that being part of the TAPS study would have on these people, whether because of the objective approach adopted by TAPS and/or because some ex-long-stay patients had been followed-up several times by TAPS and had, therefore, been over-researched. Evidence of this negative effect was most obviously seen in the positive response to being asked to participate in the research shown by the Clerkenwell residents, who had not yet been followed-up by TAPS.

It may have been possible to counteract this negative effect if she had been able to personally meet the ex-long-stay patients. There appeared to have been a variety of reasons why she was not given this opportunity - the desire

of carers and workers to protect the privacy of the ex-long-stay patients and also the resolve of carers and workers not to create a situation which could leave them open to criticism. Further, the long time gap between securing the agreement, in principle, of managing agents to assist the researcher in making contact with their residents and the actual request to put this into practice due to staff changes and other events which resulted in a 'change of attitude'.

She, consequently, had to rely on carers and workers to broach the subject of participating in the research, on her behalf, and she was uncertain how diligent, or encouraging, they were in doing this.

Staff changes, shortages, sickness, holiday leave and heavy workloads seemed to account for the other main problems that she encountered. These were reflected in the length of time waiting for replies to telephone calls and letters which, in the case of Cornwallis, resulted in her not being able to approach the residents until after they had been followed-up by TAPS with the resultant negative effect.

Although it was possible to justify why she had only been able to interview just over a quarter of the targeted ex-long-stay patients, it was felt that this number was too small, given that the focus of the research was ex-patients.

Whilst carrying out the research, she had become aware, from the build-up of comments made by professionals interviewed and visits to The Avenue, an LBI Day Centre for people with mental health problems, that other ex-patients

of Friern Hospital, that is, those who were not part of the closure programme and for whom no special provisions had been made, may have a different experience of 'care in the community' than the ex-long-stay patients that she had been concerned with. In order to increase the number of ex-patients interviewed, and to compare the experience of the ex-long-stay patients interviewed with that of other ex-Friern patients, she decided to try to trace and interview some people in this latter group. As already outlined, they would be called 'ex-patients'.

#### INTERVIEWS WITH EX-PATIENTS

In the course of conducting interviews with ex-long-stay patients at the above-mentioned Day Centre, (The Avenue) two workers mentioned that they thought some of the other people attending the Centre might be interested in talking about their experience of hospital and community life.

The researcher had also attended 'events' at this Day Centre and the new Manager was an ex-ACO and, therefore, familiar with her research. She wrote to the Centre Manager, seeking her cooperation in finding people who would be willing to be interviewed. The only criterion that she insisted was fulfilled was that the people to be interviewed should have some connection with Friern Hospital.

In the meantime, she compiled an interview schedule for use with these ex-patients. This was the same as that used with ex-long-stay patients except that some questions were reworded to take account of the different domestic situations, community involvement, contacts, and experience

of Friern Hospital, that she expected these people to have. Also, it began with questions on the Day Centre, which was a point of reference she could share with these people, and ended with questions on Friern Hospital which they might find sensitive. A copy of this interview schedule is contained in *Appendix 4.16*.

From the researcher's observations of the people attending the Centre, she decided that it would not be necessary to interview carers/workers/contacts about them, since they should be able to give 'a good account' of their experiences (Tomlinson et al 1996<sup>4</sup>).

A week after her letter to the Day Centre Manager, a Centre Worker telephoned her to say that it would be in order for her to carry out interviews at the Centre. He would put up posters about taking part in the research, and follow-up anyone who seemed interested. He would also speak personally to individuals known to be ex-Friern patients about being interviewed. He did mention that it would take time to arrange the interviews because some people only attended the Centre on certain days. Due to the length of time it had taken to contact the interviews with ex-long-stay patients, the researcher had already over-run the shut-off date for the research by nine months. She, therefore, fixed a deadline of two months to interview any ex-patients who agreed to take part in the research.

A total of eight ex-patients attending The Avenue agreed to be interviewed and were interviewed, within the time allocated. Three had been long-stay patients and three had been short-stay patients, before the Friern closure

programme began. Two had been short-stay patients while the Friern closure programme was in progress. The interviews lasted between 40 and 80 minutes each and, as expected, these people all gave 'a good account' of their experiences (Tomlinson et al 1996<sup>4</sup>). They were all extremely grateful for the five pounds for participating and the majority said that they had enjoyed the interview, or found it helpful to talk about their experiences and problems. The accounts of the eight ex-patients interviewed at The Avenue are the subject of Chapter 11.

Because of the frankness with which these people talked about their problems, the researcher found it very difficult to ignore their requests for help. She, consequently, mentioned the IMHF to three people and agreed to find some basic information on a particular problem suffered by another, and sent it to her via the Day Centre's Duty Service, whose task it was to help people with their problems. The Centre Manager was very pleased that she had drawn their attention to this problem.

Since the Centre was about to be 'assessed' and, in view of the goodwill shown by everyone at the Centre, she agreed to send the Centre Manager a report on what the people interviewed had said about the Centre, with regard to opening times, activities, and how it compared with other Centres. This was done without naming the people interviewed, and was said by the Centre Manager to be very helpful. She also said that, in view of the fact that the people interviewed had felt that this one-to-one interview situation which had allowed them to talk about their

problems had been such a positive experience, they may try to duplicate this approach in the Centre, as they had recently been concerned that people had been experiencing difficulties which they did not know about and were, therefore, unable to help them with.

The researcher concluded, therefore, that the interviews with the ex-patients at The Avenue had not only been valuable in terms of increasing the total number of ex-Friern patients in Islington interviewed to 18 and allowing the comparison between the experiences of those who had been part of the closure programme and those who had not, they also appeared to have had an immediate practical benefit at The Avenue. However, the extension of the time allotted to conduct interviews with ex-patients meant that the time available to focus on community attitudes was seriously reduced.

#### ATTENDANCE AT RESIDENTS MEETINGS

The researcher attended one Residents Meeting in Islington as an 'observer'. The meeting had been called to discuss the proposal to convert a residential property in Aberdeen Road into a home for seven elderly demented women from Friern Hospital. A member of TAPS and LBI SSD's Friern Closure Programme Officer gave her their interpretations of two previous meetings about this project.

She was introduced as a 'researcher' and noted the proceedings of the meeting in shorthand. For example, information given about the project, the concerns, fears, questions, and objections raised by residents, and how



professionals replied to these. She was given copies of the plans for the project by LBI's Architect. She also attended the LBI Town Hall when the proposal to change the use of the property was discussed. She again noted the comments made in support of, and in opposition to, the planning application, before permission was finally granted.

This was the only Residents Meeting for projects in Islington and application for planning permission which took place while she was conducting 'fieldwork'. They are discussed in Chapter 8. In view of concerns raised about the 'look' of this project, she also decided to photograph the property before building work began and after it was completed and these appear in the Appendices relating to Chapter 8.

#### SURVEY OF COMMUNITY ATTITUDES

The researcher first plotted the location of all the known residential projects for Friern ex-long-stay patients (listed in *Appendices 4.2 & 4.3*) and the main Centres and Drop-Ins (described in *Appendix 4.7*) as well as any other mental health facilities in Islington on a map of the borough. This appears in *Appendix 4.17*.

She had intended to conduct a survey of community attitudes to mental illness, mentally ill people, other disabled groups, psychiatric hospitals, and projects in Islington for Friern patients, in communities surrounding two of the operational residential projects. She decided to target communities surrounding residential projects because housing was a precondition of the long-stay patients on the

Islington wards of Friern being discharged to the community, some of the Day Centres had been established for a very long time, so local communities had had time to become used to them, and others were not situated in the midst of residential areas.

She anticipated two main problems with this part of the research - defining a 'community', and the risk of stirring-up old, or creating new, hostilities to projects. She decided to limit the 'community' to one or two streets immediately surrounding two projects, and to choose projects where the risk, or effect, of creating hostilities would be minimal.

She began compiling short 'profiles' of the areas surrounding the Shaftesbury Road, Cloudesley Road, Clerkenwell, and Aberdeen Road residential projects. These profiles were concerned with housing stock, land-use, and population characteristics which Dear & Taylor (1982)<sup>5</sup> referred to when defining 'accepting' and 'rejecting' communities, and also any community reaction to the projects. These profiles were compiled from reports on any reaction from the community if and when planning permission had been sought, since the project had been operational, and from her own knowledge and observations and those of project workers.

She also drafted a questionnaire to be used in this survey, with reference to those used by Dear & Taylor (1982)<sup>5</sup> (McMaster University, Ontario, Canada - Project 215, *Community Attitudes Toward Neighbourhood Public Facilities*, June 1978) and Nunnally (1961)<sup>6</sup> (Appendix 1, p259-264). She

intended (personally) to deliver the questionnaire to 100 households surrounding each of the two projects, so that she would have an opportunity to explain the contents, and arrange to collect it later, in an attempt to secure a better response.

However, due to the length of time (12 months longer than anticipated) that it had taken to approach and interview the Islington ex-long-stay patients and their carers/workers/contacts, and other ex-Friern patients, there was no longer time to conduct this part of the research. Thus, evidence of community attitudes to projects in Islington can only be deduced from second-hand reports of community reactions, the first-hand observation of a residents meeting and application for planning permission, and the accounts of the ex-long-stay patients and their carers/workers/contacts who were interviewed.

#### A CONSIDERATION OF METHOD, BIAS AND FINDINGS

The exclusion of the survey of community attitudes, the use of informal techniques in face-to-face interviews with 26 individual professionals and one group of professionals, 12 ex-Friern long-stay patients (two of whom were in the Pilot study) and their 'carers', another eight ex-Friern patients, the observation studies and the interpretation of secondary data placed this research firmly at the qualitative end of the research method continuum.

The researcher's view of social reality had dictated the focus of the research into this particular area of study and the 'subjects' in turn had reinforced the need to adopt

a qualitative approach. As discussed in Chapter 2, with an awareness of one's own biases, clearly defined questions and a professional approach to fieldwork, the qualitative data produced from this research could provide a meaningful insight into this area of study which would be a suitable basis for analysis and comparison.

As this chapter has shown, the researcher had clearly defined questions and she adopted a professional approach to fieldwork. The only initial bias that she had was that she considered Friern Hospital to be an extremely gloomy place and would personally have dreaded having to live there, or visit close friends or family there. On her first visit to the hospital, however, a patient who had lived there for 40 years, and who was escorting her to the TAPS Unit, asked her to tell 'them' that he did not want to leave Friern because it was his home. She, therefore, resolved to bear in mind that many long-stay patients may consider Friern to be a place of safety, an 'asylum' in the positive sense (Tomlinson et al 1996<sup>4</sup>), and that she should be concerned to find out if they would have this in the community when the hospital finally closed.

In adopting a qualitative approach in an attempt to provide a valid picture of the experience of patients moving from the hospital to the community, the researcher was not 'condemned' to be purely subjective, evaluative, limited to analysis at the micro level, and unable to generalise from the findings for a number of reasons. She would be gathering some 'objective' data, and some of the 'facts' would 'speak for themselves'.

Further, the area of study concerned the implementation of a major change in social policy, and since social policy is influenced by economic, political, and humanitarian considerations, it is concerned with social structure. Also, the nature of the hospital, community, and patients which made up the 'universe' being studied were clearly defined and likely to have many features in common with their counterparts in other areas, thus providing the opportunity for comparison and generalisation.

The 'universe' being studied was also part of a large-scale study focussing on the collection of objective data, which would provide a framework for comparison. By attempting to understand and explain how the people involved experienced the hospital closure and care in the community, the researcher was adding to, or embellishing, the findings of the objective, large-scale study, thus providing a more valid picture of the social reality being investigated and, consequently, a firmer base from which to make recommendations.

She, therefore, concluded that the findings of this qualitative study, with its emphasis on the recipients of care, would be of value to NETRHA (or its successor) and the district health authorities which come under its jurisdiction, since results from studies undertaken in the locality in which authorities operate can be used confidently as the basis of planning, and NETRHA's programme of closing hospitals for the mentally ill had only just begun.

The findings should also be of value to planners and providers of mental health services in other parts of the country where large hospitals are scheduled to close as well as researchers working in the mental health field.

If the findings of the research were of value to the above, then the researcher hoped that the ultimate beneficiaries would be people with mental health problems.

#### REFERENCES - CHAPTER 4

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## CHAPTER 5

### SCHIZOPHRENIA

#### INTRODUCTION

According to the TAPS Report (NETRHA, 1988)<sup>1</sup>, more than 80% of Friern long-stay patients had been diagnosed as suffering from schizophrenia. Since the main subjects of this study were to be ex-Friern long-stay patients, the researcher concluded that it was essential to have an understanding of this condition before interviewing ex-Friern patients and interpreting their responses.

From a wider perspective, schizophrenia is important because of the large numbers of people it affects - approximately 1 in every 100 before the age of 40 (Mitchell, 1975<sup>2</sup>), and the productive years of life it eliminates. There has also been no change in the rate of schizophrenia in the last 150 years (Hare, 1967<sup>3</sup>). Given the policy of closing the large mental hospitals in England and Wales there will, therefore, be a growing number of people suffering from schizophrenia in the community in the future.

Schizophrenia literally means 'split mind' from the Greek schizein, to split and phren, mind. However, the very extensive literature on schizophrenia shows that this literal meaning of schizophrenia is inadequate to describe such a complex condition. In this Chapter, the researcher discusses the following aspects of schizophrenia in the context of this particular study, that is, with reference to the policy of closing the large mental hospitals and providing care in the community for people suffering from

schizophrenia: diagnosis; symptoms and types of schizophrenia; the aetiology of schizophrenia (biogenic and environmental theories); treatment (physical, psychosocial, and preventative); the social environments in which people suffering from schizophrenia live; outcome; and, the rehabilitation and resettlement of people suffering from schizophrenia.

### DIAGNOSIS

According to the anti-psychiatry movement (Szasz 1961<sup>4</sup>, Scheff 1966<sup>5</sup>, Goffman 1961<sup>6</sup>), schizophrenia is a condition created by those who label it, and relatives psychiatrists, the police, and doctors may all be implicated in this social construction of schizophrenia, and stigmatised as the people responsible for it.

The problems of using reliable and independent criteria in psychiatric diagnoses are undeniable, especially if the psychiatrist lacks an understanding of the language, behaviour, and culture of the 'patient' and considers, for example, a natural reaction to racial prejudice to be a form of paranoid schizophrenia (Littlewood & Lipsedge, 1982<sup>7</sup>). The US-UK Diagnostic Project (Cooper et al, 1972<sup>8</sup>) and the International Pilot Study of Schizophrenia (WHO, 1973<sup>9</sup>), which used a standard technique of interviewing patients known as the Present State Examination (PSE), however, allowed psychiatrists to achieve a degree of agreement as to the symptoms present irrespective of language or culture.

The above shows that the diagnosis of schizophrenia may be a matter of perspective. This has several implications



for this study. Given the previously large population of the old-style mental hospitals, there may be insufficient beds available in hospitals in the community to allow appropriate diagnostic procedures to be carried out when these large mental hospitals finally close. Further, psychiatrists will no longer be the only professionals involved in diagnosis which may cause professional conflicts, and professionals, relatives, and the police may all have a vested interest in securing or dismissing a diagnosis of schizophrenia. The effects of misdiagnosis or conflict over diagnosis may be considerable if they result in a delay in treatment or inappropriate treatment.

The anti-psychiatry perspective on diagnosis tends to deny the handicap (Creer & Wing, 1974<sup>10</sup>, p2). However, the symptoms of schizophrenia show that the 'handicap' of this condition is considerable.

#### SYMPTOMS AND TYPES OF SCHIZOPHRENIA

The US-UK Diagnostic Project (Cooper et al, 1972)<sup>8</sup> and International Pilot Study of Schizophrenia (WHO, 1973)<sup>9</sup> found that approximately two thirds of all those given a clinical diagnosis of schizophrenia described experiences equivalent to Kurt Schneider's (1971) 'first rank symptoms', for example, thought disturbances, hearing voices, and the feeling that one's will or behaviour are being controlled by external forces (Salzinger 1973<sup>11</sup>, Wing 1978<sup>12, 13</sup>).

When this central syndrome was present, there were always a wide range of other symptoms: perceptual abnormalities often interpreted as delusions or

hallucinations of different senses; mood-based abnormalities frequently concerned with ruination and punishment; content-based symptoms usually of a persecutory, religious, fantastic, and sexual nature; monosymptomatic delusions which reflect a preoccupation with a single over-valued idea; and, a full range of neurotic symptoms.

Two types of chronic schizophrenic syndromes were also identified - the Clinical Poverty Syndrome and Schizophrenic Thought Disorder which were equivalent to Emil Bleuler's (1911) 'flattening of affect' and 'loosening of associations', respectively (Salzinger<sup>11</sup> 1973, J K Wing 1978<sup>12,13</sup>). The Clinical Poverty Syndrome is characterised by emotional apathy, slowness of thought and movement, underactivity, lack of drive, poverty of speech and social withdrawal. Schizophrenic Thought Disorder is characterised by problems with all forms of communication but is most often seen in speech which can be vague, empty, meaningless, distorted and incoherent.

Acute schizophrenia may occur in limited episodes with little chronic impairments, and chronic schizophrenia can occur with no history of acute episodes. Alternatively, there may be a combination of acute and chronic symptoms. Adverse social conditions such as unemployment, poverty, prejudice, and lack of a social network may add to the social disablement of 'schizophrenics' by making them physically and psychologically vulnerable and less able to deal with intrinsic impairments (Wing, 1978<sup>13</sup>).

Despite the diversity in the symptomatology of schizophrenia, psychiatrists have distinguished several

different types which have been outlined by many commentators (Salzinger 1973<sup>11</sup>, Mitchell 1975<sup>2</sup>, Arieti 1981 p53-60, and Gallagher 1987<sup>15</sup>). These have been summarised in *Appendix 5.1*.

The symptoms of schizophrenia can, therefore, be both frightening and socially disabling for sufferers. However, to 'others' the symptoms of schizophrenia are not only difficult to understand and threatening, but often invisible. People suffering from schizophrenia are, therefore, hard to identify with, they are strangers in our midst and, like other unknown entities, may elicit fear, rejection, and hostility.

The behaviour associated with some 'types' of schizophrenia may be particularly noticeable in the community. For example the 'giggling' of people suffering from hebephrenic schizophrenia, and the incoherent and incessant speech of people suffering from a form of catatonic schizophrenia. Also, the persecutory and grandiose delusions of the paranoid schizophrenic, when accompanied by an hallucination with a strong religious content, for example, that the individual is Jesus Christ or the Virgin Mary may be very alarming if they result in that individual assuming the bitter, hostile and often aggressive attitude of someone unfairly victimised.

Given the policy of closing the large mental hospitals, many more people suffering from schizophrenia may find it difficult to go 'unnoticed' in the community by virtue of their symptoms. If they are shunned, provoked, or treated cruelly in the community, this may reinforce their

delusional thinking and feelings of persecution and even the most docile could become dangerous and display the sort of behaviour the public originally feared, in accordance with the self-fulfilling prophecy theory outlined by H Becker (1963)<sup>16</sup>. If there are insufficient hospital beds in the community, then people suffering from schizophrenia who display the sort of behaviour that the public fears will come in contact with the police, courts, prisons and be dealt with in the same way as other people who are considered to be socially dangerous.

It is, therefore, the nature of some of the symptoms of schizophrenia which generates the fear of people suffering from schizophrenia and a climate of fear is clearly detrimental to the success of community care. However, fear of any condition can be dissipated through knowledge of its possible causes.

### THE AETIOLOGY OF SCHIZOPHRENIA

Theories on the aetiology of schizophrenia fall under two general headings - Biogenic and Environmental.

#### Biogenic Theories

Evidence to support the theory that schizophrenia has a hereditary basis comes from family, twin, and adoption studies.

If one parent is schizophrenic, then a child has about a 10% chance of developing schizophrenia and if both parents are schizophrenic then the risk increases to about 40%

(Slater & Cowie, 1971<sup>17</sup>). The higher rate of concordance for schizophrenia in monozygotic (identical) than dizygotic (fraternal) twins, 46% and 14% respectively, further implicates the role of genes (Gottesman & Shields, 1982<sup>18</sup>). The familial clustering of schizophrenic cases shown by studies which identify and follow-up in adulthood the children of schizophrenics adopted shortly after birth into unaffected families (Heston, 1966<sup>19</sup>), and those which trace the biological and adoptive relatives of registered schizophrenics (Kety et al, 1978<sup>20</sup>) confirm the genetic influence.

However, since there is never 100% concordance, these studies show that it is not schizophrenia itself that is inherited but only a vulnerability for it, and that this vulnerability must be combined with sufficient environmental stress to produce schizophrenia (Meehl, 1962<sup>21</sup>). There is also evidence to suggest that it is the severe cases of schizophrenia which can be attributed to a genetic defect (Gottesman & Shields 1973<sup>22</sup>, Kallman 1953<sup>23</sup>).

Since the observation in the 1950s that mescaline and LSD could produce temporary schizophrenic symptoms in 'normal' people, and the discovery (albeit later discredited) of a compound in schizophrenic urine which produced a 'pink spot' on paper chromatograms (Friedhoff & Van Winkle, 1962<sup>24</sup>), the Transmethylation and Dopamine Hypotheses have stimulated a great deal of research into biochemical abnormalities. Although this line of enquiry is validated by the idea that any genetic disposition to react

adversely to stress would be reflected in specific biochemical abnormalities, and is justified by the desire to find more effective and less toxic medication, biochemical abnormalities may also be the consequence of schizophrenia. (Birchwood et al, 1988<sup>25</sup>).

Barry & Barry (1961)<sup>26</sup> were among the first to demonstrate an excess of winter births in individuals later emerging as schizophrenic, and subsequent large-scale population studies in northern and southern hemispheres confirmed their findings (Birchwood et al, 1988<sup>25</sup>). Interest in prenatal theory has been enhanced by the idea that season-related environmental agents such as viral infections and nutritional deprivation among the poor are responsible and that these are compounded by living in an urban environment (Rieder et al 1975<sup>27</sup>, Machon et al 1983<sup>28</sup>, Gallagher et al 1983, 1984<sup>29</sup>).

Environmental factors are also implicated in Morphological Theory, that is, that people with a fragile slender build which Sheldon & Stevens (1942)<sup>30</sup> called an 'ectomorphique' physique may be the victims of economic deprivation causing nutritional deficiencies, and that the association between morphology and abnormal behaviour in schizophrenia is likely to be due to social learning (Gallagher, 1987<sup>15</sup>).

Thus, those who favour Biogenic Theories have failed to find a specific disease agent which is a necessary and sufficient cause of schizophrenia. However, they have shown that there is a propensity in certain individuals to develop

schizophrenia and it is clear from some of their work that environmental factors play a substantial part in this.

### Environmental Theories

#### The Influence of the Family

Since the 'schizophrenogenic mother' was identified by Fromm Reichman (1948)<sup>31</sup>, some of the most severe critics of the family are those who have been concerned with its influence on the development of schizophrenia. Theories on the influence of the family tend to begin with a different definition of schizophrenia - it is not an illness of the mind but an understandable response to a specific situation.

Freudian psychoanalysts believe that schizophrenic regression, which is manifested through social withdrawal, is the result of frustrating weaning experiences and being denied the comfort of a warm mothering figure. As fears, conflicts, and fantasies which individuals experienced during the earliest phases of psychosocial development are revived, they drift into a dream world in which people and objects appear to merge.

Behaviour Theorists regard schizophrenia as conditioned or learned behaviour which, like normal behaviour, is largely determined by environmental stimuli. It is not a problem within the individual but the result of interaction with other people. In the two types of family structure identified by Lidz et al (1957)<sup>32</sup> as being causal in the emergence of schizophrenia, abnormal behaviour is seen as a learned response to the fact that the parents behave inappropriately for their age and sex, to each other and the

child and constantly alter the 'facts' to suit their own emotionally-determined needs. In the Double Bind Theory of Bateson et al (1956)<sup>33</sup>, schizophrenic thought disorder is a consequence of the ambiguity of intafamilial communication. It develops as a result of the problems the child experiences in attempting to respond to contradictory messages emanating from one or both parents, although the mother is usually the key figure.

From an Existentialist perspective, R D Laing (1960)<sup>34</sup> argues that schizophrenic behaviour makes sense in terms of the meanings and interactions that develop within the family. The individual elected to the role of madness in a Good-Bad-Mad progression by an insidiously demanding family escapes from the strain of family life into a dream world (Sedgwick, 1982<sup>35</sup>). In Laing's work with Esterson (1964)<sup>36</sup>, the family as a whole bears the attributes of the schizophrenic syndrome. The parents are scarcely less confused and thought disordered than their disgraced offspring and the psychiatrist, who is an agent of social control, pins the label of 'schizophrenic' on the family member selected to bear the burden of a sick society.

Existential theory, like other theories on the influence of the family is difficult to test, and research usually focuses on 'abnormal' families whose disturbed interpersonal relationships may be the consequence and not the cause of schizophrenia, which ignores the possibility that the same processes may be at work in families which do not produce a schizophrenic member (Brown et al, 1966<sup>37</sup>). However, these theories do enhance our understanding of the



behaviour of people suffering from schizophrenia, and the fact that some of these people do improve when they are removed from the family situation and benefit from therapy which changes their role in the family, shows that these theories cannot be discounted because of lack of empirical evidence alone.

### Epidemiology

Those who have studied the prevalence and incidence rates of schizophrenia have contributed much to our understanding of this condition.

Schizophrenia can occur at any age but the onset of schizophrenia is commoner in young people, and the years of highest risk are 15-45. There is little difference between the sexes in the overall rate of schizophrenia in England but the highest rate in men is in the age group 15-24 after which the risk gradually decreases, and in women it is in the age group 25-34 after which it does not decrease so sharply (Wing, 1978<sup>12</sup>). There are several explanations of these sex differences, for example, women do not encounter so many stressful situations as early as men, women are more able to cope with the demands of life by virtue of their socialisation, and they become more vulnerable later in life because of the menopause.

The incidence of schizophrenia is fairly evenly distributed among the different social classes. However, there is a tendency for people who become thought disordered to lose their ability to function successfully at work, and to 'drift' into poverty, 'skid' into the lower classes, and

also for downward social mobility to precede the onset of schizophrenia, typically at puberty, which impairs school achievement and future work prospects (Goldberg & Morrison, 1963<sup>38</sup>).

This observation of the 'drifting' of pre-schizophrenics and people suffering from schizophrenia into the lower classes has come to be known as the 'Drift Hypothesis' (Hollinghead & Redlich, 1958<sup>39</sup>), and came from the discovery that schizophrenia was more concentrated among unskilled and low status occupation groups (Odgaard 1957<sup>40</sup>, Brooke 1957<sup>41</sup>). This observation was originally taken as an indicator that schizophrenia had its origin in the lower class and was explained by the desire of members of this class to escape from stressful life conditions and other forms of deprivation and break with reality in search of relief from their misery - the 'Stress Hypothesis'.

The Drift Hypothesis, which describes the course of schizophrenia rather than its cause, has been used to explain the concentration of schizophrenics in inner cities (Hare 1956<sup>42</sup>, Walsh 1969<sup>43</sup>, Rowitz & Levy 1968<sup>44</sup>), and among single people who live alone (Hare 1956<sup>42</sup>, Dunham 1965<sup>45</sup>, Malzberg 1964<sup>46</sup>). However, people suffering from schizophrenia may have actively sought the anonymity of areas that are characterised by lack of community and the opportunity to develop social relationships and decided to segregate themselves.

The displacement of the Stress Hypothesis in favour of the Drift Hypothesis does not mean that stress is unimportant. Brown & Birley, 1968<sup>47</sup> found that 60% of

people suffering from schizophrenia had experienced a stressful life event, for example, marriage, death, leaving job, moving house, three months prior to admission to hospital. Although these life events are not all unpleasant, they can all be stressful in that they confront pre-schizophrenics with some change in their social environment and increase the demand on them for social adaptation. Confirmation of the precipitating role of stressful life events on the onset of schizophrenia comes from studies on the effects of migration, immigration, childbirth, and entry into the army (Hare 1967<sup>3</sup>, Malzberg 1964<sup>46</sup>, Pugh et al 1968<sup>48</sup>, Steinberg & Durrell 1968<sup>49</sup>).

Thus, those who favour environmental theories can only identify social factors which may cause schizophrenia in those who have a vulnerability towards it and describe their situation at the time they become 'ill'. However, they have also highlighted the importance of the social environment with regard to the treatment and outcome of schizophrenia.

The above summary of the Biogenic and Environmental Theories of schizophrenia shows that the nature/nurture debate on the aetiology of schizophrenia has not been resolved, that is, the cause of schizophrenia is uncertain. This means that the fear generated by the nature of 'schizophrenic' symptoms cannot be dispelled by knowledge about its cause. Further, this accumulation of fear cannot be halted by certainty about the efficacy of the treatment of schizophrenia, as the following section shows.

## TREATMENT

### Physical

Psychosurgery has always been used as a last resort in extreme cases, but Insulin Coma Therapy and Electro-Convulsive Therapy (ECT) have not been used so sparingly, despite lack of evidence of their efficacy. ECT, which was a product of the 1940s, involves chemically-inducing convulsions to produce relief from extreme symptoms such as acute withdrawal. As a 'shock' therapy, it was preferred to Insulin Coma Therapy because it involved fewer hazards to life and limb, and was easier to apply.

Many of the recipients of ECT, and some observers of its adverse effects such as memory loss, however, have not felt able to justify the frequency of its usage in these terms. Organisations such as MIND, who are concerned with the welfare and rights of the mentally ill, regard ECT as a far more sinister and life-shattering treatment than the shock therapies of old, such as 'cold bath remedies', especially when administered against a patient's will. From a learning theory perspective, Dies (1968)<sup>50</sup> has described ECT as a negative reinforcement - people want to avoid ECT so they suppress the behaviour that led to their initial punishment. However, it has no long-range benefits because they are not taught alternative responses.

ECT was largely displaced as a maintenance treatment in the 1950s with the introduction of the phenothiazines, whose discovery was largely accidental (Birchwood et al, 1988<sup>25</sup>, p230-34). Phenothiazine, which was first synthesized in 1883, made its medical debut in 1934 as a urinary antiseptic

and insecticide, followed by a chemical derivative, promethazine, which was found to have antihistamine and sedative properties. In 1952 in Paris, Charpentier synthesized a further derivative, chlor- promazine, which was found to have a potent therapeutic influence on disturbed and agitated patients, alleviating hallucinations and delusions.

Chlorpromazine and its derivatives (trifluoperazine and fluphenazine), which had no sedative properties, began to be widely used, in tablet form, and their usage was accompanied by an optimism in their efficacy in the treatment of schizophrenia. Chlorpromazine and a chemically-similar group of compounds, the thiozanthenes, and a chemically-distinct group, the butyrophenones, later became available in injectable form and known by their Trade names - Modecate, Depixol, and Haldol Decanoate.

These drugs can be injected into the gluteal muscle every two to four weeks. They diffuse slowly into the bloodstream which ensures continuity of effect and are not subject to metabolism by the liver, as they are in tablet form. Drug treatment by injection is also considered to be more reliable because it is often difficult to ensure that people suffering from schizophrenia are taking their medication in tablet form, due to the nature of their impairments, especially in an unsupported environment. This became an increasingly important consideration as the desire to first reduce the size of hospital populations, then close large hospitals and care for people in the community gradually became a reality.

The course and outcome of schizophrenia was not totally bleak before the introduction of phenothiazines, and it was not totally satisfactory afterwards. That is because they are not a 'cure' - they do not significantly reduce the chance of lifelong recovery after acute episodes, and they can only ameliorate chronic impairments such as slowness and apathy. Phenothiazines do, however, have a number of advantages. They can be easily administered, they are relatively safe and predictable, and they can suppress some of the acute symptoms of schizophrenia. They act as a stress-buffer which reduces suffering and allows some people to live outside hospital (Leff et al, 1982<sup>51</sup>), and they can help to prevent relapse (Hogarty, 1984<sup>52</sup>).

Relapse can cause increased stress to sufferers which may result in them harming themselves. There is also the danger that people suffering from schizophrenia will commit violent offences if they do not take their medication regularly, as the case of Paul Gordon (The Guardian, 1993)<sup>53</sup>, a 'schizophrenic' who became a 'killer mugger' as a result of not taking medication, illustrates.

However, if phenothiazines are taken regularly for a long time, the side-effects can be considerable. People show marked personal differences in their sensitivity to both the therapeutic and side-effects of these drugs, and for some the costs may outweigh the benefits. Many people report a feeling of being 'damped down', but the most prominent adverse effects are those which affect motor control.

Birchwood et al (1988)<sup>25</sup> have divided these motor anomalies into four subgroups: Acute dystonic reactions - muscle spasms involving the head and neck which may also affect vision; Akathisia - restlessness and agitation, seen in pacing up and down, fidgeting, and moving repetitively; Parkinsonism - stiffness, tremor, shuffling gait, and dribbling; and, Tardive dyskinesia - involuntary movements of the head and tongue, and problems with speech, posture, and breathing. (p235-236)

Motor anomalies can occur in 40% of cases and be as disabling and visible as the symptoms of schizophrenia. Tardive dyskinesia generally emerges at 12 months or more after the commencement of long-term treatment and it can be a permanent handicap which persists after drugs are withdrawn. Drugs to control the side-effects of phenothiazines also have their own side-effects. (p236)

According to Cawley (1967)<sup>54</sup>, the therapeutic effect of phenothiazines is their ability to calm people down, and make them amenable to other forms of treatment. They allow staff to handle patients in a way which respects their human dignity, and does not forget their interaction with the environment, which was the aim of William Tuke's 'moral treatment' in the 18th century (discussed in Chapter 6). Cawley argues, however, that the optimism about the success of drug treatment has a placebo effect in that it acts as a deterrent to obtaining more information about side-effects.

ECT is often advocated as an adjunct to drug treatment, particularly in those with depressive features. Brandon et al (1985)<sup>55</sup> found that ECT led to a much quicker improvement

in schizophrenic and depressive symptoms in medicated patients but this was only short-term - at 12 weeks follow-up, there was no apparent benefit.

Johnson (1985)<sup>56</sup> found that unnecessarily high dosages of the phenothiazines were used in clinical practice, and Kane et al (1983)<sup>57</sup> found that when lower dosages were used, fewer early signs of tardive dyskinesia were observed, and that relapse could be aborted by a prompt increase in the level of medication. Thus, there is a case for keeping dosages to a minimum in an effort to reduce harmful side-effects.

#### Implications for this Study

The above discussion has several implications for this study. Firstly, it is unknown whether the dosages of the phenothiazines administered in the hospital will be adequate in the community for long-stay patients discharged as a result of hospital closure. Secondly, since the side-effects of drug treatment may be as disabling and visible as the symptoms of schizophrenia, they may also result in people suffering from schizophrenia becoming the focus of rejection and ridicule in the community.

Thirdly, with the closure of large mental hospitals, there may be more people suffering from schizophrenia living in less supported environments in the community in which their medication-taking is not properly supervised or where they are encouraged by organisations like MIND to exercise their right to refuse medication or demand lower dosages. If this leads to an effusion of florid symptoms and a



situation in which ECT is the most practicable remedy, then this effectively constitutes the infringement of the rights of individuals to appropriate care and a choice of treatment, especially the psychosocial variety.

*The Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)<sup>58</sup>, a 'paranoid schizophrenic' who was charged with the murder of Jonathan Zito at Finsbury Park Underground Station in December 1992, noted that a wide spectrum of care was not available. It recommended that the assessment of aftercare needs of individual patients must take into account their own wishes and choices and that although aftercare is not provided by medication alone, non-compliance with medication should be recognised as a significant pointer to relapse. (p110)

The report also recommended a nationally-based register of patients requiring special supervision who could be recalled to hospital if they failed to comply with their aftercare plan or their mental health deteriorated. People who satisfied two of the following criteria would qualify: detention under the Mental Health Act 1983; a history of violence or persistent offending; failure to respond to treatment; homelessness. Although the inquiry acknowledged that the majority of people suffering from schizophrenia were living safely in the community, it felt that if the needs of the small group requiring special supervision were not met, community care would be discredited and it may be perceived that the policy had failed. (p112-116)

The inquiry concluded, as did their 'witnesses', that community care was the right approach to caring for mentally

ill people and they had no wish to return to the days of locked, impersonal, dehumanising and undignified institutional care. (p115)

### Psychosocial

The observation that the therapeutic effect of drug treatment often comes from social and psychological factors, for example, the high morale of staff and the idea that schizophrenia can be treated, coupled with the problem of side-effects, has encouraged the development of psychosocial interventions, which can augment drug treatment and sometimes afford therapeutic relief in their own right.

According to R D Laing (1961)<sup>59</sup>, schizophrenia is a natural way of healing the state of alienation called normality. Consequently, people should be guided through schizophrenia and medical treatment aimed at cutting-short schizophrenic episodes of symptoms should be avoided because it is anti-therapeutic.

Birchwood et al (1988)<sup>25</sup> describe how the use of psychoanalytic techniques in the treatment of schizophrenia was pioneered by H Sullivan in the 1920s and later extended by his associate Fromm-Reichman (1952)<sup>60</sup> who patiently and gently probed the defences of her clients. Rogers (1967)<sup>61</sup> reinforced the potential value of genuine, empathetic listening in client-centred therapy and subsequent workers have explored a variety of existential and humanistic techniques. (p230-231) However, given the sophisticated cognitive demands inherent in facing the existential realisation of one's ultimate isolation and gaining insight

into one's self or past experience, the feasibility of employing such techniques with the majority of people suffering from schizophrenia, as an alternative or adjunct to drug treatment, is uncertain.

Birchwood et al (1988)<sup>25</sup> describe how a range of more promising psychosocial procedures has emerged from work in the field of social, cognitive, and behavioural psychology (p231-232). The clinical approach in which these procedures have found application is commonly known as behaviour modification. Craighead et al (1976)<sup>62</sup> has summarised the key features - tools of behavioural influence are selected on the basis of a functional problem analysis.

The earliest examples of behaviour modification with schizophrenics was based upon the principles of operant conditioning. The analysis of the problems of hoarding and delusional talk in terms of their environmental consequences and modification by strategies such as extinction and reinforcement (Ayllon & Michael, 1959<sup>63</sup>) led to the creation of remotivating environments in the form of token economies. In recent years, the range of tools used in behaviour modification has been broadened to include other principles of learning - observational, classical conditioning, methods of cognitive change, and self-regulation.

The negative influence of the family and the effect of stressful life events on the emergence of schizophrenia has already been discussed. Therefore, interventions which involve helping families to identify stressful circumstances which precipitate psychotic episodes and develop stress-reducing strategies have also been effective in the

treatment of schizophrenia. From their work on expressed emotion, Leff et al (1982)<sup>51</sup> developed a family therapy which consisted of: educating relatives about the nature, course, and treatment of schizophrenia; forming a relatives group in which a therapist facilitated interactions between them; and, holding individual sessions with families, using dynamic interpretations or behaviour modification.

Work therapy, whether carried out in a hospital or community setting, is also effective in the treatment of schizophrenia. This involves setting individuals a task which is geared towards their particular capabilities. This task is usually simple, manual, and repetitive and it acts as a neutral stimulus to which they can respond without over-involvement and the reactivation of florid symptoms. It also minimises the risk of the appearance of negative symptoms caused by an under-stimulating environment, by reducing the time people spend doing nothing. Similarly with art and music therapies which also allow individual expression and are particularly effective with people who are socially withdrawn or have verbal communication problems.

### Preventative

The section on the aetiology of schizophrenia showed that although a vulnerability to schizophrenia can be inherited, a healthy environment can counteract the development of this condition. This means that it is inappropriate to recommend lifetime birth control, voluntary sterilisation, and

therapeutic abortion in order to prevent the transmission of schizophrenia to the next generation. Prevention, therefore, must take other forms.

Arieti (1981)<sup>14</sup> has discussed two forms of prevention - Longitudinal and Critical (p159-60). Longitudinal prevention aims at assisting the individual throughout life, especially early life, to avoid or modify the effects of circumstances, developments, or lasting situations that enhance the risk of transforming what was only a propensity towards schizophrenia into the actual clinical appearance of this condition. However, this form of prevention requires families to seek professional help before the need for such help becomes obvious.

Creer & Wing (1974)<sup>10</sup> found that a common difficulty for relatives was the prevailing negative attitude to schizophrenia which arises from ignorance. Schizophrenia is frequently regarded as something totally disastrous and unmentionable, and is associated with sensational newspaper articles. Consequently, some relatives feared they would lose their jobs or be cut off from the wider community if it was known they were related to a 'schizophrenic', and often said they were suffering from depression because it is a more socially acceptable condition. This means that some families may be reluctant to admit that one of their members has such a problem and seek help in the early stages. (p36)

Creer & Wing also found that many relatives encountered difficulties in obtaining help from GPs and Social Services at the very beginning, when preventative measures might have been effective. This seemed to be because schizophrenia

often begins in late teens or early 20s, a time when difficult or odd behaviour 'normally' occurs. When parents were 'brushed off' by GPs, they were reluctant to approach them again. The unhelpfulness of GPs appears to have been caused by a lack of knowledge of schizophrenia, since the parents of 'schizophrenics' who were themselves GPs said they had known little about this illness before they had personal experience of it. (p38)

According to Arieti (1981)<sup>14</sup>, critical prevention aims to help people to avoid or cope with the type of stressful events that precipitate schizophrenic episodes. Drug therapy and psychosocial interventions can all be used in the critical prevention of schizophrenia. However, since stressful events are intimately or symbolically related to the individual's psychological nature, it is not always possible to predict the meaning a particular event will have for a particular person, and it may be difficult to intervene without infringing on their rights.

In the context of this particular study, the above discussion shows that the public, in general, and GPs in particular should be educated about schizophrenia. This is because families who may carry the burden of caring for people discharged from hospitals scheduled to close and those who suffer from schizophrenia in the future and their first port of call, GPs, must be knowledgeable about the causes and symptoms of schizophrenia to make early detection and successful intervention possible. Given the beneficial effect of work therapy, the education of employers who can supply the type of work that people suffering from

schizophrenia can undertake would also be advantageous. However, a public education programme on a national scale and not just focused on communities targeted to receive the first long-stay patients who are discharged would require substantial financial resources.

Many people, however, recover independently of treatment, some do not seem to respond to any treatment, and almost any treatment appears to be effective for as long as the professionals and the patients are enthusiastic about it. This phenomenon which can be likened to the 'Hawthorne Effect' discovered by Elton Mayo in 1932, shows the importance of the social environment for the treatment and outcome of schizophrenia.

## SOCIAL ENVIRONMENT

### The Hospital

For many people suffering from schizophrenia, the psychiatric hospital has for long or short periods been their social environment. There is evidence to suggest that it is those who display extreme behaviour, that is behaviour which is considered to be harmful to themselves or others, or socially unacceptable, who are hospitalised (Smith et al, 1963<sup>64</sup>). However, in the absence of considerable deterioration, an acute episode, or grossly exaggerated symptoms, there is no special reason for keeping schizophrenics hospitalised if they are 'adequately treated' in their home communities (Pasaminck et al, 1967<sup>65</sup>).

This has several implications for this study. With the closure of the large mental hospitals, there may not be

enough beds in the community to cater for people with extreme behaviour who would previously have been hospitalised. This extreme behaviour is likely to make them very noticeable in the community and there is the danger that they will become both the victims and perpetrators of hostility. Further, to be 'adequately treated' in the community, people suffering from schizophrenia must receive at least the same level of care as they would have in the large mental hospitals.

It has long been recognized that 'institutional neurosis' (Barton, 1959<sup>66</sup>) which is characterised by loss of individuality, resignation, apathy and withdrawal is the consequence of living for long periods in a 'total institution'. This term was used by Goffman (1961)<sup>6</sup> to describe the custodial psychiatric hospital which controls all aspects of patients lives and progressively undermines their will to do anything for themselves, and in which staff are more concerned with running the establishment efficiently than meeting patients' needs. Further, the longer people stay in hospital, the less likely they are to practice everyday social roles, and the less likely they are to want to leave (Wing, 1961<sup>67</sup>).

However, for people suffering from schizophrenia, the hospital environment can fulfil many requirements. It offers protection at times when they are not in control of their own thinking and behaviour and may be a danger to themselves or others. It caters for their basic needs when they are in a state of confusion and regression which may result in them refusing food or fluids. It also offers the



opportunity for observation, diagnosis, and the initiation of treatment. A hospital stay removes people from the environment in which their conflicts arose, are perpetuated, and where they may be misunderstood and become the victims of rejection and hostility. It also provides relief to family members who are caring for them.

For long-stay patients, the large mental hospital is, therefore, a 'home', a 'place of safety', and a 'total community' in which they live, work, socialise, and form relationships with people who can understand, accept, and sympathise with the symptoms of their illness. Thus, for long-stay patients to be 'adequately treated' in the community, the community must provide services to fulfil all the functions of the large mental hospital. This will require substantial financial resources, since communities will not be able to 'buy in bulk', an option which was available to the large mental hospitals by virtue of the large numbers they were accommodating.

*The Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)<sup>58</sup> found that due to an accumulation of failures and omissions by a number of people and agencies, he was not provided with the good and effective care required to keep him well and the public safe. It noted the shortage of beds in Medium Secure Units and general psychiatric hospitals in London which could result in inappropriate care, premature discharge, relapse and readmission. It also noted that there were insufficient residential hostels and supported housing and identified the need for long and short stay 'haven type' accommodation - a

refuge or sanctuary which is medically staffed and supervised to care for those unable to cope in the community or to provide respite for friends and relatives. (p121-122)

The inquiry considered lack of resources to play a part in the failures and missed opportunities in the case of Christopher Clunis and were concerned that these were being reproduced country-wide especially in poor inner city areas, that is that Christopher Clunis was not alone - many more people living in the community were at risk to themselves or others (p105). The inquiry acknowledged that a considerable injection of funds would be required to rectify the identified deficiencies and to provide an appropriate spectrum of care. However, they had the impression that the general public would consider that money spent on keeping mentally ill people well and the public safe would be money well spent.

*"The admission or on-going treatment of patients who present clear risks to themselves or the public at large should not be determined by the economies of the market place." (p122, 51.0.8)<sup>58</sup>*

### Under and Over-Stimulating Environments

Enforced idleness is a characteristic of an under-stimulating social environment (Barton, 1959<sup>65</sup>), which can increase negative symptoms associated with the Clinical Poverty Syndrome and these symptoms become more intense the longer people stay in hospital (Wing & Freudenberg 1961<sup>67</sup>, Wing & Brown 1970<sup>69</sup>). However, people suffering from schizophrenia are also vulnerable to over-stimulating social environments. Increased stimulation can lead to a relapse

with a effusion of florid symptoms (Stone & Eldred, 1959<sup>70</sup>).

Although an under-stimulating social environment has been most frequently observed in the large old-style mental hospitals, it can also occur in the community - people can be just as inactive in a badly organised, under-resourced, and/or custodial Day Centre and display the same negative symptoms. Further, an over-stimulating social environment can easily be created in a previously under-stimulating social environment as a result of over-zealous therapy intended to facilitate the movement of patients from a hospital scheduled to close to the community.

#### The Family Environment

It has already been noted that the family can have a negative influence on the aetiology of schizophrenia. However, the family environment can also be under or over-stimulating and, therefore, detrimental to the treatment and outcome of schizophrenia.

Brown et al (1966)<sup>37</sup> found that severely handicapped patients living at home were just as likely to spend long periods of time doing nothing as their counterparts in the hospital and that relapse was associated with three measures of emotion expressed by relatives - critical comments, hostility, and emotional over-involvement. Creer & Wing (1974)<sup>10</sup> also found that people with chronic schizophrenic handicaps living at home had become so withdrawn that they were leading almost solitary lives in the family. Alternatively, they could behave in ways which were socially

embarrassing or threatening and which drew attention to their condition, for example, being excessively active and noisy at night, engaging in pointless repetitive activities, neglecting personal hygiene and appearance, being unnaturally suspicious, displaying odd posturing, laughing to themselves, talking to voices, and threatening to commit suicide. (p36-37)

Further, Creer & Wing found that parents often experienced guilt because they felt they were to blame for the condition and could not share the burden of the unhappiness it had caused to their offspring. They could also become frustrated and angry because nothing they did seemed to help and because they were concerned about what would happen when they could no longer cope, or died. Relatives, in general, often became physically and mentally exhausted caring for 'schizophrenics' at home, and socially isolated from friends, neighbours, and the wider community. Due to the prevailing negative attitudes to schizophrenia, they did not invite people to their home because they feared they would be shocked or embarrassed by the schizophrenic's behaviour and they were prevented from going out because the schizophrenic did not like being left alone. (p38)

Although people suffering from schizophrenia do not wish to be alone, they like to control the intensity of their contacts. It may, therefore, be difficult for relatives to provide the required level of detachment and neutrality, as the studies of expressed emotion in relatives conducted by Vaughn & Leff (1976)<sup>71</sup> demonstrate.

With regard to this study, many families will have experienced the anguish of having to resort to leaving their relatives in large mental hospitals when they could no longer cope with caring for a 'schizophrenic' at home. They may have welcomed the closure of the large mental hospitals and the opportunity to become the primary agent of, or play an important participatory role in, community care, in the belief that they would be given support and respite care for their relatives.

However, if community care is under-funded, the full responsibility of care may fall to many families, and some people suffering from schizophrenia may not have families who are willing or able to take up this burden. If the family was the place where an individual's conflicts arose and the family is unable to provide an appropriate social environment for their care, then the consequences, in the form of negative symptoms, for the sufferer, their family, and the community may be serious. When the large mental hospitals finally close, there may no longer be a 'place of safety' in which to treat negative symptoms, and living on the streets or in prisons may be the only alternative for some people suffering from schizophrenia.

### The Optimum Environment

According to Wing & Brown (1970)<sup>68</sup>, the optimum environment for schizophrenics is one which is well-structured with clear lines of behaviour laid down, and has a neutral type of social stimulation which does not lead to emotional over-involvement, thus minimising thought disorder and social

withdrawal. In this sort of environment, little may be required in the way of drug treatment.

However, the previous sections have shown that a wide range of social environments are required to cater for the varied and ever-changing needs of people suffering from schizophrenia as a result of the diversity in their impairments, response to treatment, and social circumstances. In the context of this study, this means that substantial financial resources will be required to provide the necessary number and variety of social environments in the community for people suffering from schizophrenia once the large hospitals finally close.

Given that the side-effects of drug treatment can be both disabling and visible, the environment in which people suffering from schizophrenia are treated is not only an important consideration with regard to their rehabilitation and resettlement but also to the final outcome.

## OUTCOME

There are certain aspects of schizophrenia which are considered to be favourable or adverse to the final outcome. Arieti (1981)<sup>14</sup> has summarised these (p159-160). Favourable aspects are: an acute beginning; the existence of an obvious precipitating factor, for example, loss of job; conscious anxiety, since this is an indication that the 'blunting of affect' has not eliminated emotion; a stormy type of personality; compliance with doctors, nurses, and therapists; and, the ability to lie or pretend, since the

power to abstract facts is required to get rid of delusions and other 'unreal' entities.

There is also evidence to suggest that being part of a family can positively affect the outcome of schizophrenia. For example Cooper (1961)<sup>72</sup> found that 'schizophrenics' living alone were worse in terms of clinical improvement, rate of discharge from hospital, and total time spent in hospital than those living in a family setting.

According to Arieti (1981)<sup>14</sup>, the adverse aspects are: a slow insidious beginning; the absence of precipitating factors or psychological causes; lack of emotion; a marked schizoid type of personality; an attitude of defiance to doctors and nurses; blaming others for their situation; and, acceptance of the illness and resignation to the sick role.

Most commentators agree that the recovery rate for people suffering from schizophrenia is approximately 66%, although for some this is only social recovery, and there are different levels of recovery with resultant liabilities to relapse which have implications for 'quality of life'. In a study of 120 patients discharged from hospital over a period of 5-9 years, Johnstone et al (1985)<sup>73</sup> found: 18% had recovered to the extent that they had no significant symptoms and were functioning satisfactorily; 38% were impaired with regard to personal care (hygiene, appearance, diet); and, 38% were functioning poorly in their social role (work and home).

Of the people who recover, some perceive their illness to have been a helpful experience in that it has caused a reorganization of their personality. They now see

themselves, the world, and the future in a different way. They feel 'reborn' and, consequently, are unlikely to suffer a relapse.

For many people, 'recovery' merely means that they have lost the symptoms of schizophrenia and returned to the same state that existed prior to the onset of illness. They learn to deal with life in that they can usually cope or avoid anxiety-provoking situations, but they are not 'cured' because they still have the same personality whose weaknesses made them vulnerable to the first attack. Relapses can, therefore, occur and although they are generally moderate, their intensity and frequency can be determined by the nature of the social environment.

Some people still show slight signs of schizophrenia but they are better able to adjust to anxiety-provoking situations than just prior to the onset of illness. Others show definite signs of illness and are unable to recapture the level of adjustment they had prior to onset. They often tend to lack spontaneity, the ability to concentrate, a sense of commitment, and a desire to participate. They require gentle and constant stimulation, and can only make very slow progress on the road to recovery.

Those who maintain an over-riding suspiciousness and sometimes still hear imaginary voices and express bizarre ideas can, generally, only cope by reducing their life to a routine. Consequently, they lead very impoverished lives and are very susceptible to relapse.



### Implications for this Study

The susceptibility to relapse of people suffering from schizophrenia means that many may require hospitalisation in the future. Given the previously huge populations of the large mental hospitals, the community may not be able to cope with the demand for hospital beds in times of relapse from ex-long-stay patients who may have found it difficult to adapt to living in the community, people who were formerly described as 'revolving-door' patients, and those just embarking on a 'schizophrenic' career, when the large mental hospitals finally close.

For all those who only attain partial recovery, the main goal seems to be to live a satisfactory life, in spite of the residue of illness, while still striving for complete restoration of their mental health. The course and outcome of schizophrenia can be improved if the knowledge of this condition, and its treatment and management is skilfully applied.

This is an aim of the National Schizophrenia Fellowship, the largest voluntary agency for people with schizophrenia and their families. By providing information and advice, and putting people in touch with other, they believe that relatives are better able to resist uninformed pressures from other members of their family or the general public and help the family member who has developed schizophrenia. Similarly, with MIND who also employ people who are present or past victims of schizophrenia, in an effort to give them the opportunity to re-build their lives and use their experience to help others.

This aim can, however, be thwarted by adverse media representations of people suffering from schizophrenia. The Glasgow Media Group (Dept of Health for Scotland, 1993)<sup>74</sup> found that press accounts and television portrayals of mentally ill people, in general, were characterised by ignorance and fear. These perpetuated the myth and stigma of mental illness, and increased the fear of mentally ill people and becoming mentally ill. Although there is no significant association between mental illness and violence, the press and television frequently connected 'mad' with 'bad'. This was particularly noticeable in characters in television soap operas, since even when people had had direct experience of mental illness, this did not override the television profile. There was also a tendency to 'poke fun at' mentally ill people in a way which would not be acceptable on a racial or sexual dimension.

Given the sensitivity of people suffering from schizophrenia to their social environment, the negative influence of the above-mentioned media representations of mentally ill people on public perceptions and attitudes can be a deterrent to the early detection, treatment, and outcome of schizophrenia. This again suggests the need for a public education campaign so that the stigma attached to schizophrenia can begin to be eroded and 'schizophrenics' will no longer be regarded in such fear-provoking and stereotyped ways and treated with hostility which may elicit the behaviour the public originally feared. The high cost of such a campaign is justified if the successful rehabilitation of people suffering from schizophrenia and

the resettlement of long-stay patients who are discharged to the community as a result of hospital closure is a priority.

#### REHABILITATION AND RESETTLEMENT

According to Wing (1963)<sup>75</sup>, rehabilitation is the process of helping individuals make the best use of their residual abilities in order to function, at an optimum level, in as normal a social context as possible. However, although the nature of schizophrenic impairments imposes limitations on the achievements of sufferers, schizophrenia does not impose a uniform personality and inadequacy upon them. This means that rehabilitation systems must have adequate facilities and manpower to account for the great variability between 'schizophrenics' with regard to degree of social disability and the level of independence they may achieve.

Birchwood et al (1988)<sup>25</sup> note that psychosocial difficulties and behavioural problems are fairly pervasive features of schizophrenia and observable, to varying degrees, in community-based, acute first episode and first admission, and 'new' long-stay schizophrenics, as well as chronic institutionalised patients. Rehabilitation services to facilitate resocialisation, deal with skill deficits, and counteract dependency and inactivity should, therefore, be routinely available for all, not just selected long-stay patients being prepared for discharge. (p311)

According to Birchwood et al (1988)<sup>25</sup> rehabilitation systems should have a psychiatric hospital with a rehabilitation ward and other facilities of different size and structure to cater for clients with different needs and

goals and which will provide opportunities for, and training in, a range of domestic, social, leisure, and occupational activities. They should also have transitional facilities designed to resemble discharge environments and provide opportunities for training, and a range of residential facilities to meet the varying needs of clients with regard to training, support, and supervision. These include long-term hostels, short to medium-term training homes, group homes with different levels of supervision, sheltered housing, warden-controlled flats, and substitute families and fostering. There must also be support for clients living in their own bedsits, flats, and houses. Further, given the social isolation and inactivity of schizophrenics living in the community, a particular concern of rehabilitation systems must also be the provision of a broad range of day and evening facilities which offer opportunities for further skill training, work, occupation, recreation, and social contact. (p136)

Birchwood et al (1988)<sup>25</sup> also note that the setting-up of rehabilitation systems, in the hospital and the community, depends on the involvement of sufficient numbers of professional staff, drawn from many disciplines, who collectively provide wide-ranging skills, expertise, and experience, and operate in an effective multi-disciplinary manner. However, the extensive needs of schizophrenics cannot be met by professional health and social services staff alone and, if the community is to accept greater responsibility for its disadvantaged members, the input of non-clinical and voluntary organisations is desirable to

complement and facilitate statutory provision by providing advice, welfare counselling, social contact, recreation, and transport. Families and friends should also be included in the rehabilitation system and given support so that they can play an important participatory role.

Thus, arrangements should exist to facilitate coordinated planning by statutory agencies, such as health authorities and local authority social services and housing departments, and non-statutory groups such as mental health organisations and housing associations.

Good rehabilitation policy not only requires the availability of adequate resources. Service managers, who are responsible for determining priorities and patterns of provision, must also be aware of the needs of the clients for whom they are providing. Service providers must be appropriately qualified, trained, and motivated if rehabilitation systems are to be successful, since the mere provision of facilities is no guarantee of the achievement of rehabilitative goals.

There must be service integration to ensure the smooth movement of clients within and between hospital and community settings. Agencies and staff in different settings must coordinate their activities and work cooperatively, otherwise the needs of certain clients will go unrecognised and unmet. Facilities must be properly structured, have clearly established and expressed operational policies on, for example, objectives, referral and selection criteria, assessment procedures, and evaluation techniques. Although the afore-mentioned are

largely procedural and organisational issues, they must be adequately addressed if people suffering from schizophrenia are to benefit from rehabilitation systems. (137)

In order to satisfy all Birchwood et al's (1988)<sup>25</sup> criteria for successful rehabilitation systems, substantial financial resources are undoubtedly required. However, one of these authors' criteria is 'the psychiatric hospital' and with the closure of the large mental hospitals and the resultant demand for hospitals beds in the community, it is unrealistic to expect District General Hospitals to fulfil this key role in rehabilitation work. This has serious consequences for the 'quality of life' of all people suffering from schizophrenia, not just ex-long-stay patients.

The term rehabilitation has, however, hitherto been most commonly used to describe the process of preparing long-stay patients for discharge to the community. One impediment to the rehabilitation of long-stay patients in large old-style mental hospitals is their own negative attitude to discharge, as a result of long-term institutionalisation (Wing, 1961<sup>66</sup>). According to Wing & Brown (1970)<sup>68</sup>, increased contact with the outside world in the form of a planned system of travelling by public transport, other everyday activities and trial visits to the community is probably the best way to change negative attitudes to discharge in selected patients.

With the closure of the large mental hospitals, the aim of rehabilitation is no longer just discharge, but resettlement. The goal of resettlement is to attain the

level of achievement in domestic life, work, leisure, and personal relationships that the person was striving towards before schizophrenia intervened. Expectations of social achievement vary with culture, class, age, sex, and previous attainment, and they cannot just be defined in terms of only personal aims, since the individual lives in a social environment. Consequently, the expectations of others, for example, relatives, neighbours, and employers must also be taken into consideration. Professionals must, therefore, make both clinical and social evaluations to identify attributes which may hinder resettlement and, consequently, require attention.

Thus, those involved with resettling long-stay patients must be aware of their individual impairments, areas of sensitivity, interests, and motivations, and design a programme to take account of these. They must seek to exploit attributes and skills which have not been affected by the illness and praise even very small accomplishments, in order to build-up self-confidence. If people are asked to tackle or cope with things that are beyond their immediate capability, they may feel overwhelmed and are likely to relapse.

The policy of closing large mental hospitals can be viewed positively with regard to some long-stay patients suffering from schizophrenia because it has made them the focus of rehabilitation and it has made some resources available for their resettlement. Many old-style hospitals were under-resourced for a long time and only able to offer custodial care. Patients became long-stay by virtue of the

serious nature of their impairments, the effect of institutionalisation, because they had a poor level of social competence and low expectations before being admitted to hospital, and because of the inability or unwillingness of their family, or any other agency, to house and support them, if they were discharged. In hospitals which did operate small rehabilitation programmes, prior to the closure policy, the afore-mentioned problems precluded them from taking part. The longer they remained in hospital the less eligible for rehabilitation, and the more reluctant to leave, they became.

For many long-stay patients, therefore, the goal of resettlement may seem unattainable or take a very long time. If they are to be successfully resettled in the community, their rehabilitation must begin in a sheltered environment in which they feel secure - the hospital. However, their level of achievement may be determined by the morale of hospital staff. If staff feel threatened by the hospital closure, or are overworked because of inadequate resources, this is likely to be low with a resultant adverse effect on the patients with whom they are engaged in rehabilitation work.

Also, there is no guarantee that the way patients 'perform' in hospital is a true indication of how they will manage in the community, which is not a sheltered environment. There must, therefore, be adequate resources to make facilities available to ease their transition from the hospital to the community, to provide a wide range of permanent residential settings designed to meet their varied



and changing needs and opportunities for occupation, recreation, and social contact in the community, and their ongoing support and care once they are finally discharged.

If there are inadequate resources, then those who considered the long-term commitment of people suffering from schizophrenia to an institution to be a deprivation of freedom must also ask if being forced to move out of a hospital which is scheduled to close, after many years, into a place 'unknown' with inadequate facilities for their care is also not an infringement of rights. If there are inadequate resources, then the policy of closing the large mental hospitals and caring for long-stay patients and other people suffering from schizophrenia in the community cannot be viewed so positively. This is because, for all its adverse effects, the hospital was a 'place of safety' for those who had been unable to cope in society, and it provided for all their basic needs.

The National Schizophrenia Fellowship are particularly concerned that schizophrenic patients discharged from hospitals scheduled to close are not receiving a continuing circle of care in the community. If there are gaps in community services, or they are underfunded, and 'schizophrenics' do not receive coordinated medical care and support, they may become isolated and suffer relapse bringing turmoil to their own lives and those of their families.

In conjunction with other voluntary organisations such as MIND, SANE, and CONCERN, they have highlighted the shortfalls in community care. People with schizophrenia who

cannot turn to their families for accommodation and support have to try and cope on their own. Given the increase in homelessness, a great many are forced to wander the streets, and some choose crime and suicide as a relief. These organisations are particularly concerned about the numbers of 'schizophrenics' in court and prison instead of hospital because there is nowhere else for them to go, which is punishment, not care.

There have been numerous media accounts which highlight the failure or non-existence of rehabilitation systems. For example, The Guardian (1993)<sup>76</sup> report of the conviction of D McBean, a 'schizophrenic' compulsorily detained under the Mental Health Act 1983 and released after a short period, for the rape of three women. The 'tabloids' are not usually so objective in their reporting and their sensational accounts of the 'crimes' of 'schizophrenics' in the community pay little attention to the possibility that these perpetrators may, themselves, be 'victims' - of inadequate rehabilitation systems.

As Chapter 6 will show, the care of mentally ill people in England and Wales has 'historically' been characterised by containment, maltreatment, and neglect. Given the large numbers of people suffering from schizophrenia traditionally residing in the large mental hospitals, the movement to a policy of community care can only be considered to be a positive one if the criteria outlined for successful rehabilitation and resettlement are applied and the inadequacies discussed above are addressed. This requires a firm financial commitment.

Without a firm financial commitment to provide a wide range of facilities and services in the community to meet the varied and ever-changing needs of people suffering from schizophrenia and to create, at the very least, a tolerant attitude to them in the community via a public education campaign, then community care will be a well-intentioned but unrealistic aim based on a nostalgic notion of communities which are concerned about, equipped, and ready to support its weakest members.

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C H A P T E R    6  
AN 'HISTORICAL' CHAPTER

INTRODUCTION

The question of whether or not to include an 'historical' chapter in a social policy-orientated thesis and what form this should take is largely determined by the aim of the research and the researcher's answer to the question 'What is history'?

Carr (1961)<sup>1</sup> outlines how, in the 19th century, the positivist approach to history, like the natural and social sciences, was to first ascertain the 'facts' and then draw conclusions from them. According to this common-sense view of history, there are certain basic facts which are the same to all historians who collect and present them, and they form the backbone of a history which is written by individuals for individuals.

The 19th century was a confident and optimistic period, and the liberal view of history had a close affinity with the economic doctrine of 'laissez-faire'. The basic facts of history were satisfactory and the majority of British historians held a linear view of history, a demonstration of the principle of progress, a notion which had clearly been articulated by evolutionary social theorists such as Herbert Spencer.

Carr argues, however, that these basic facts do not exist objectively and independently of the interpretation of the historian. They are the raw materials of the historian who selects and presents them, rather than of history. Since the historian can largely get the facts he wants, they are really

a series of accepted judgements which became historical facts via the process of selection and interpretation and, consequently, 'make' history - "*The facts do not speak for themselves, they only speak when the historian summons them*" (Carr, 1961, p8)<sup>1</sup>.

Carr describes how the challenge to the primacy and autonomy of facts in history came from German philosophers such as Dilthey in the late 19th century. Drawing on their work, the Italian B Croce in 'History as the Story of Liberty' described all history as 'contemporary history'. By this he meant that history essentially consists of seeing the past through the eyes of the present and in the light of its problems. The main work of the historian, therefore, is not to record but to evaluate, otherwise how can he know what is worth recording?

Croce's philosophy became more popular in Britain after the First World War because it diminished the prestige of 'facts' which were, by then, far from satisfactory. Carr notes that it was an important influence on Collingwood whose analysis in 'The Idea of History' (1945) reflected the two current meanings of the word 'history' - the enquiry conducted by the historian and the series of past events into which the historian enquires. The past which the historian studies is not a dead past but one which is, in some sense, still living in the present, but a past act is dead or meaningless to the historian unless he can understand the thought behind it. Thus Carr (1961)<sup>1</sup> concludes that "*All history is the history of thought*" (p16).

Carr describes history as a social process in which individuals are engaged as social beings, in a reciprocal process of interaction between the past and the present. The historian is also part of history and moves along with it, but his stand-point is rooted in his social and historical background. History, like sociology is necessarily subjective since man is observing himself. The process of observation is affected by the social position of the observer and this affects and modifies what is being observed. Since there is no such thing as society at rest, both the historian and the sociologist must study social change and development. Carr (1961)<sup>1</sup>, therefore, further concludes - "*The more sociological history becomes and the more historical sociology becomes, the better*" (p60).

Weeks (1985)<sup>2</sup> describes how Michel Foucault's approach radically challenges any general theory of history 'as a lesson, as an exhortation, and as inextricably combined with politics'. Foucault's work is historical and about social practices but he is not writing a history of society. Each analysis starts from a problem and seeks to define it by what Cousins & Hussain (1984)<sup>3</sup> call a 'case-history'. In historical analysis, the question of evidence is controlled by exhaustiveness, in a case-history it is handled in terms of its intelligibility. With 'histories', the emphasis is on development which is the difference between their present and their origin. Foucault is not concerned with origins but with beginnings, not with causes but with emergences and effects. He rejects the category of progress which serves as a theoretical end in that it permits him to underline the

differences between things which are usually subsumed into the identity indicated by progress.

Following Max Weber, the researcher concluded that just as the subject matter and methods of any sociological research are 'value-laden', so the role that researchers assign to history is based on a 'value judgement' (Runciman, 1978)<sup>4</sup>. The way that they interpret past events will also be a reflection of their own values, and often influenced by some present purpose or future vision. The researcher further concluded that even if sociologists do not adhere to a clearly defined view of history, they should, especially if they are engaged in social policy-orientated research, have an historical awareness.

The subject matter and purpose of this research required that the researcher have an understanding of the history of the mental health services in England and Wales leading up to the decision to close Friern Hospital in order to place the history of Friern, which is the subject of Chapter 7, in a wider historical context. However, the history of the mental health services has already been presented, notably by Jones<sup>5</sup> (1972), and there have also been challenges to Jones' and other traditional interpretations of the 'facts' in this history.

The researcher, therefore, decided to first present the different interpretations of the history of the mental health services in England and Wales leading up to the decision to close Friern under the following broad headings: early perceptions of madness; the asylum system; the first half of the 20th century; the move towards the policy of community

care; the policy of community care; and, models of madness.

In conclusion, she discusses themes which emerged from this presentation which have important implications for this study in particular and for the future welfare of people with mental health problems in general. They were: the stigma attached to mental illness and to sufferers: the harsh treatment and neglect of mentally ill people; fear of mental illness, professional fear of loss of prestige, and fear of inadequate care; inequality in the care and treatment of mentally ill people; their low status and priority; and, ambiguities, conflicts and lack of consensus in policy for mentally ill people.

#### EARLY PERCEPTIONS OF MADNESS

Early perceptions of madness are important because of their immediate influence on public attitudes to mentally ill people, their treatment and management and on any residual effect they may have today.

#### Madness as Unreason and Evil

Until the latter part of the 18th century, there were two prevailing perceptions of madness - as Unreason and Evil.

Foucault (1971)<sup>6</sup> describes the perception of madness in the Classical Age as a form of Unreason, that is, opposition to established reason in which both the mind and body were implicated. There were a complex of social categories which stood outside Reason - idlers, vagrants, criminals, and madmen. It was a matter of choice and, therefore, morally culpable.

Jones (1972)<sup>5</sup> describes how, as late as the 18th century, mental disorder was associated with sin and activities of the devil which resulted in many mentally ill people being branded as witches. Even when the Penal Laws against witchcraft were removed in 1736, the lower classes retained a superstitious fear of the insane.

The so-called medical men of the 17th and 18th centuries believed that mental and moral defect were synonymous. Moral condemnation also characterised the attitude of the church and philosophers practised condemnation by omission by largely ignoring the mentally ill in their deliberations. The notion that human misery was the result of personal sin, that the poor and sick deserved their Fate, and that it was not for man to interfere with the work of God, acted as a scapegoat for the rich and powerful - the sufferings of the less fortunate were not their responsibility. Jones (1972)<sup>5</sup>, therefore, concludes:

*Superstition, moral condemnation, ignorance and apathy; these were the attitudes which dominated the treatment of mental disorder in the eighteenth century and they were inevitably reflected in the pattern of administration." (p5)*

### Harsh Treatment and Neglect

Donnelly (1983)<sup>7</sup> describes madness as a 'great leveller' of social distinction for it reduced its victims to the humiliation of being without reason and led to loss of human station. Jones notes that until the latter half of the 18th century, the confinement of the insane, whether they were rich or poor, living in a town or the country, was characterised by neglect and harsh treatment.

Foucault describes how the perception of madness as Unreason meant that there was no consideration for the humanity of madmen - they could be chained up like wild beasts or become the victims of the therapies of 'distraction' and 'awakening' which were used by some 18th century 'mad-doctors'. These involved terrorising madmen to cause such extreme emotional and physical discomfort, which was often stronger than the madness itself, that their bodies and minds were shocked into a new disorder which allowed them to be brought back from the world of Unreason.

Jones outlines how the association of mental illness with evil led to the use of harsh treatment to drive the devil out of the lunatic. The ordeal by water used in witchcraft was emulated by the medical profession under the guise of 'cold bath remedies' and even King George III was not exempt from the indignity of purges, vomits, and blood-letting.

Since there was no clear definition of mental disorder at this time, and the insane did not exist as a separate category in law, there was no recognition that they required a distinct form of treatment. If they wandered from their legal place of settlement, they came under the Vagrancy Laws, if they committed crimes the Penal Law, and if their mental condition reduced them to poverty, the Poor Law.

As a result, many mentally ill people were to be found in Workhouses where they had to endure the same squalid conditions and punishments as other paupers. The criminal insane went to Gaols and Bridewells and shared the same humiliating conditions as other inmates until an Act of 1763 separated them because it had been found that they disturbed

and often terrified other prisoners. Many mentally ill people were kept at home by their families in a variety of conditions. Some were tied in a corner to prevent them being a nuisance while others were looked after in a caring environment sometimes receiving medical attention. However, there were class differences in the treatment of madmen in the 18th century - gentlemen were less likely to be chained and pauper lunatics were more likely to become incurable and die.

Bethlem Hospital in London was the only public institution for the insane and they were confined 'en masse'. Its nickname 'Bedlam' suggests the scene within - one of mad confusion and uproar, a spectacle the public readily paid to watch on Sunday afternoons. Many insane of social standing were 'put away' to avoid scandal and to be forgotten about, usually in establishments run for private profit. These private madhouses were rarely inspected and people confined at the insistence of relatives had little protection against illegal detention.

#### Madness as a Mishap

In the latter half of the 18th century the perception of madness and its treatment began to change. Jones outlines several reasons for this. Firstly, allegations of wrongful detention in private madhouses increasingly aroused public concern because of the fear that a sane person who was harshly treated could be driven insane. This led to an Act in 1774 for licensing and inspecting these establishments and resulted in more humane treatment for some.



Secondly, as a result of the growing number of pauper lunatics, there began to be greater speculation about the causes of insanity and about whether poverty and insanity were in a reciprocal relationship. Thirdly, public knowledge of King George III's illness in 1788 resulted in madness becoming a more respectable illness - the King could not possibly be possessed by the devil and if it could happen to the King, it could happen to anybody. Consequently, there should be sympathy for the sufferer not condemnation, madmen should be treated and not punished, and there was the possibility of a cure.

According to Foucault, it was this perception of madness, as a mishap, which removed the aura of culpability and led to a conception of madness, not as Unreason, but as a disorder of Reason which afflicted humans without affecting their status as human beings, and was susceptible to cure. It was this change in the perception of madness that led to gentler treatment.

Jones describes how the improvement in public attitudes was reflected by the setting-up of institutions such as the York Retreat by William Tuke and the Society of Friends in 1792 after one of their members, Hannah Mills, died in the York Asylum where starving patients were chained in dark, filthy solitude and where flogging was routine.

### The York Retreat

The York Retreat had seven staff and 30 patients, initially all Quakers. The cost of treatment ranged from eight to 15 shillings with an additional fee for the accommodation of

personal servants. Since it had been noted that the mixing of the insane further maddened them because of their influence on each other, they were classified and separated by walls at the Retreat.

Tuke's 'moral treatment' was based on Christianity and common-sense and was applied to the responsible subject in the madman to repair his damaged mind. The doctor or 'Alienist' had mastery over the inmates by moral means using the 'power of the eye'. Nevertheless, the Retreat was a place of safety where the mentally ill were given good food, a little soothing drink, and exercise. Prayers and work for its beneficial effect on morals occupied a central place, and the allocation of tasks reinforced the distinction between different categories of insane. The inmates were never punished, rather self-control was encouraged by a show of trust and minor privileges for conforming to attendants' wishes.

Tuke's moral treatment was attractive because if patients could be cured and discharged to support themselves, they would cease to be a drain on the public purse. However, the high ratio of staff to patients, the high cost of treatment and an additional fee for the accommodation of servants showed that the York Retreat was clearly not for the poor.

According to Foucault, Tuke's 'moral treatment' did not constitute a liberation of madmen, it was merely a change in their regime of internment. As fully human, they were now subject to 'moral constraints'. This change was the culmination of a multi-faceted and disparate process which Foucault did not regard as humanitarian. This was not because he doubted that the motives of reformers like Tuke were

genuine but because its link with medical treatment gave a misleading impression of the role of doctors and medicine in the change - it was only one factor responsible for the birth of the modern asylum. Others included the transformation in the attitude to poverty and the increased importance accorded to the health of the population.

Foucault argues that Tuke did not bring a doctor to the Retreat because he wanted the medicine of madness to work in his regime of internment but because he wanted someone with the social and moral authority derived from medicine. Thus, this liberation was not an encounter between the sane who had finally realised that madmen were human and the insane who repaid this recognition by becoming orderly, but a process of exchange in which interned madmen swapped their chains and manacles for moral constraints. Corporal punishment was replaced by other disciplinary tactics, for example, silencing the madman by observing, assessing and moulding but not listening to him.

The placing of madmen in this morally ordered world, however, opened up the possibility for the designation of mental illness as distinct from physical illness. It had also shown that kindness could be more effective than rigorous confinement which encouraged reformers to believe in the asylum system.

## THE ASYLUM SYSTEM

### The Birth of the Asylum - Lunacy Reform or a Mechanism of Social Control

Jones regarded the Act of 1808, which recommended the setting-up of an asylum in each country for pauper and criminal lunatics, as an important reform in its conception of the idea that it was a public responsibility to provide treatment of a non-deterrent kind and try to deal with the cause rather than the symptoms of anti-social behaviour. According to Donnelly, institutionalisation was an understandable response to the demoralising effects of the change from rural to industrial life which led to discontents bordering on madness and the growth of urban populations which had made the domestic care of the mentally ill more problematic.

Scull (1979)<sup>8</sup> argues that the naive Whiggish view of history as progress gives a misleading picture of lunacy reform. He also identified institutionalisation as having its roots in the changing nature of English society but argued that it was embedded to a far greater extent and in a far more complex way in the nature of capitalism as a social phenomenon. According to Scull, the main force behind a segregative response was the advent of a capitalist economy at a time when the traditional patterns of rural and urban living were disintegrating along with established techniques for coping with the poor and troublesome.

The insane had become an increasingly visible and troublesome social problem. In Workhouses, they often disrupted other inmates and because of the recent revolution in France, there was a heightened fear that the disorder

within could spread to the masses outside - a working class which was becoming increasingly conscious of the evils of industrialisation and their own power. According to Scull, therefore, the setting-up of the asylum system was not just an attempt to deal with the cause of anti-social behaviour but to control anti-establishment behaviour. Institutionalisation was a way of protecting the property of the middle classes and the authority of the ruling class at a time of working class unrest and, as such, was a mechanism of social control.

However, there were not enough asylums to meet demand and because this sort of confinement was more expensive than detaining the insane in Workhouses and, despite the Poor Law Amendment Act (1834) which stipulated that they could not be kept in Workhouses for more than 24 days, there were still large numbers of insane in Workhouses, although most were now separated from other inmates.

Both Donnelly and Scull describe how the demand for places of confinement led to a veritable 'trade in lunacy'. Those operating in this developing market claimed to possess expertise and special competence and the existence of institutions provided them with the opportunity to develop their skills, attain 'professional' status and, consequently a guaranteed market for their services.

According to Smart (1983)<sup>9</sup>, Foucault describes the asylum as a regime of internment within which the relations of power have been formed and exercised, where the insane have become the objects of medical concern, and from which knowledge about the mad has been accumulated. He outlines how the internal regime of the asylum is far from fully accounted for by the

medical aim of 'cure' alone by referring to the isolation of lepers in the 16th century which was not so much a medical act, although it did prevent the spread of disease, as one concerned with the ritual of purification and exorcism of the objects of fear. Similarly, the exiling of the mad on a 'ship of fools' which plied the Rhine was not exclusively a functional measure, although it did allow towns to get rid of their insane, a ritual of cleansing, laden with symbolism.

Initially, asylum doctors did no more than reiterate the old themes of authority and punishment and create the human environment for 'cure' by filtering out those suitable for internment and supervising the internal regime of the asylum. When madness had to be certified by doctors, their authority increased and as they began to analyse and cure madness, thus creating psychiatry, they became professionals. However, madness could not have become a specialised object of knowledge and refer exclusively to a disease of the mind with the emergence of psychiatry in the 19th century without already having been an object of internment and correction.

Most asylums were large barrack-style buildings and the architecture reflected the treatment within - the large wards with heavy lockable doors symbolized the surveillance and containment of the mentally ill, patients were dealt with 'en masse' and they had little personal involvement with staff who worked for the maintenance of the institution rather than the patients' benefit. As a result, patients became increasingly depersonalised, isolated and lacking in any sense of community. The use of mechanical restraints degraded and

humiliated patients and gave keepers an opportunity to abuse and neglect their charges.

### The Motives of Dr John Conolly

As the number of county asylums increased so too did efforts at more humane forms of treatment. The practice of 'moral management' introduced by John Conolly, the Superintendent of Hanwell, one of the largest county asylums, abolished the use of mechanical devices to hinder bodily movement and introduced new ways of occupying patients - reading, writing, drawing and singing. The non-restraint method improved the general tone of the asylum but it was more expensive in that it required more staff and higher standards.

Scull (1984)<sup>9</sup> is critical of the motives of Dr Conolly who was so praised for his introduction of the non-restraint method at Hanwell. He describes how Conolly was unpopular in his early career for condemning the indiscriminate confinement of the insane, urging for the elimination of the private, profit-making madhouses, and touting the merits of domiciliary care. A decade later, however, when he was appointed Superintendent at Hanwell in 1839, he became one of the most important and effective champions of the expansion of the asylum system, arguing against those who wanted to restrict admission to lunatics who were dangerous to themselves or others. These ideas won him prestige and financial reward and by the end of his career, he reiterated his acknowledgement of the findings of medical science and the larger social order by referring to the social utility and indispensability of the private asylum system.

According to Scull (1984)<sup>9</sup>, given the prevailing view of the asylum as a mistaken approach to the problems of managing the mentally ill, *"Conolly's changing views appear to mark an almost perverse shift from enlightenment to error"* (p235).

#### The Lunatics Act (1845)

The aim of the Lunatics Act (1845) was to secure the unification of statutory control over asylums and madhouses and to extend the lunacy laws to all institutions in which the insane were detained. Jones views this Act as the culmination of a slow process of social reform which set a new standard of public morality whereby the care of the helpless and degraded was seen as a social responsibility and with which the 'lunatic' became the 'person of unsound mind'. Donnelly identifies this Act as important in that it established the insane as a separate class, defined by their mental disorder whose confinement was under state control. However, this Act did not abolish the distinction between pauper and private patients regarding certification although it did increase the legal safeguards against the wrongful detention of both.

#### Conditions in Asylums

The moral treatment offered to paupers in public asylums bore little resemblance to that developed for the middle class clientele at the Retreat. The County Asylums were overcrowded and usually had only one untrained keeper for 30 patients. Patients slept on straw and had little medical care, exercise or employment. Mechanical restraints were commonly used and there were high mortality rates. Therefore, according to



Warner (1985)<sup>10</sup> "..... *human care was for those who could afford it*" (p11).

Jones describes how, as a result of the press coverage of the continued abuses at York Asylum, the discovery of William Norris who had been confined in Bethlem for 9 years in an iron apparatus, and the 'crib room' cases of Bethnal Green, public concern was again aroused. This prompted the appointment of the Select Committee of 1815 which noted the great diversity of treatment under the existing lunacy legislation, and 1827 whose concern about the separation of sexes and moral treatment reflected the influence of the York Retreat and showed that reformers were no longer merely concerned with material standards of well-being. However, the resulting County Asylums and Madhouse Acts of 1828 did not reflect this concern since the only mention of treatment was in private madhouses - that there should be regular medical attention, restraint only by the order of the medical attendant, and a more detailed form of certification to deter illegal detention.

A series of Amending Acts providing for a closer check on certification and admission procedures did little to dispel public fear of illegal detention. This reached its height in 1884 through the activities of Mrs Georgina Weldon, a wealthy eccentric woman whose husband had tried to confine her in a private asylum in Hammersmith with little success. The growth of literacy and the increasing availability of newspapers made this a well-known case and public feeling that Mrs Weldon was a wronged woman, that asylum doctors as infringers of liberty were the villains, and that the amendment of the lunacy laws

was a priority. The legal profession was old and well-established at this time and when it pressed for legislative change, reform along legal lines, that is protection against illegal detention, took precedence and the ideas of those campaigning for reform along medical lines, that is the eradication of the distinction between mental and physical disorders, or social lines which concerned the development of more humane treatment, were swept away.

### The Lunacy Act (1890)<sup>12</sup>

The Lunacy Act (1890) drew together all existing legislation into a coherent whole and provided details for every known contingency. According to Jones, this Act represented the legal view of mental illness - a condition which made it necessary in certain circumstances to deprive man of his personal liberty, everything possible being done to limit these circumstances. From a medical and social viewpoint, this Act hampered future development because, for example, asylums could only take certified patients and patients could not be certified until their illness was obvious, so asylums could not deal with early diagnosis and treatment of the most mild or acute cases, and consequently their role was largely custodial.

Unsworth (1987)<sup>13</sup> describes this Act as the 'triumph of legalism' because it was primarily addressed to legally preventing wrongful detention. He notes, however, that it can also be accused of 'legal stigmatisation' in that the legalistic procedure imparts a 'trial' model into the commitment process which quasi-criminalizes the mental

hospital population and then conspires in its social ostracization.

According to Foucault, this Act was important because in recognising the mentally ill as legal subjects with definite rights and obligations, it allowed the asylum to bring together medicine and internment and this liaison had a pervasive influence on the mental health services for the next 70 years.

## THE FIRST HALF OF THE 20TH CENTURY

### Mental Illness and Mental Deficiency

It was not until the Mental Deficiency Act (1913) that separate legislation was provided for all categories of mental defectives. Those working with and caring for the mentally ill and mentally defective had many ideas in parallel, for example, to move away from the concept of permanent detention and try to reintegrate patients into society, yet there was a clear difference between developments in their treatment and care. This was because the early care and treatment of mentally ill people was largely in the domain of statutory organizations and salaried workers whereas mental deficiency work was a partnership between statutory and voluntary bodies with the initiative coming from the latter. Jones identifies the difference in the public's perception of the two groups as the reason for this - the mentally defective were seen as harmless, simple and weak and emotional satisfaction could be gained from protecting them whereas the mentally ill were perceived as dangerous, their unnatural bizarre behaviour was

potentially violent, and the thought of mental illness aroused painful emotions which were not to be encouraged.

### The Ministry of Health

Jones describes how the setting-up of a Ministry of Health in 1919 improved attitudes to mental illness because public health was no longer conceived of as a junior partner to the Poor Law administration only concerned with one section of the population. A year later when the Ministry took responsibility for lunacy and mental deficiency, bringing all public health under a central authority, the way was open for further assimilation in the treatment of physical and mental illness. However, since the Ministry of Health only really had financial control over local authorities and the Board of Control was only responsible for institutions, attitudes to mentally ill people and the services available to them varied considerably countrywide. According to Jones, this was because of the stigma still attached to mental illness and the lack of public knowledge and interest in this area.

### The Royal Commission (1924-26)

The Royal Commission (1924-26) was appointed because of the public's uneasiness at the large number of allegations of wrongful detention, widespread cruelty and bad administration in institutions for mentally ill people. Members of the Commission were appointed by the Home Secretary and the majority had legal qualifications.

They inquired into the existing legal and administrative machinery in England and Wales with regard to certification, detention and care of persons alleged to be of unsound mind

and the extent to which they could be treated without certification. They noted that the majority of the insane were paupers and that under the 1890 Act, they could not be voluntarily admitted to public asylums. This was a barrier to early treatment and brought with it the double stigma of insanity and the Poor Law. They, therefore, recommended the abolition of old connections with the Poor Law, legal distinctions between private and pauper patients and a reduction of legal formalities in the interests of early treatment.

The Commission felt that much of the good work being done by mental hospitals was being nullified by the lack of suitable help for patients with unsympathetic families, unsuitable home lives, and employment problems after discharge. They referred to the work of the organisation which became the Mental After-Care Association in 1949 with admiration but noted that there was no equivalent in the provinces. They, therefore, concluded that public funds should be set aside for community care to assist people in the transition from asylum to home which was in contrast to the earlier emphasis on detention.

The Commission noted that mental and physical illnesses had physical and mental concomitants, respectively which was a new idea even for the medical profession and which brought insanity further into the realm of general medicine. It recommended confining legal intervention to the protection of patients against neglect and ill-treatment, their right to proper treatment and liberty unless it was not in their own or the public's interest.

Their Report was a complete denial of the principles of the Act of 1890 and a development of the more enlightened principles of the Act of 1845. The predominance of the legal view was no longer acceptable, the medical view was completely endorsed and the social view encouraged in that after-care was now an essential part of clinical psychiatry which reflected the increased status of the medical profession, including psychiatry and the growing professionalisation of social work.

#### The Mental Treatment Act (1930)<sup>14</sup>

Under the Mental Treatment Act (1930) which abolished outmoded terminology in an attempt to disassociate mental health services from the Poor Law, the asylum became a mental hospital, the lunatic became a patient, and the pauper became a rate-aided person. This Act also recognised the need to prevent mental illness and cure the mentally ill who were now victims of social pressures rather than culpable moral failures by placing a new emphasis on alternative facilities for incipient and temporary disorders - voluntary admission, outpatient departments, wards in general hospitals and after-care. This Act was, therefore, hailed as a long overdue reform with infinite possibilities.

According to Unsworth, several factors had conspired to undermine the cherished liberal assumption of 'laissez-faire' which were all related to the condition of the working class and a fear that they may revolt - extension of the franchise, social distress in economic depression and a general revival of socialism and the development in Labour and Trade Union organisations in particular. This Act was the legislative

embodiment of the conviction that there is no clear line between mental and physical illness, therefore, insanity is a public health problem. It reflects the medical approach to legislation and legalism's strategic rejection which was partly due to the increasing prestige and influence of the medical profession. He notes the similarity between the legal and medical professions - both have a paternalistic approach and both are founded on a moral position. Therefore, this Act did not represent the liberation of the mentally ill from social control but the transfer of control from one profession to another.

There were some improvements in the mental hospitals after 1930 - patients could wear their own clothes, take part in social activities and have occupational therapy. Segregation of the sexes still existed but the admission of voluntary patients resulted in more doors being unlocked and people coming and going more freely which found its ultimate expression in the 'parole system' which attempted to break down the barriers between patients and the community.

There were, however, inadequate financial resources to set-up alternative facilities because there was no strong public mandate to find money for this in a time of post-war inflation, it was difficult to distinguish between the poor and mentally ill since voluntary admission could be a form of relief in economic depression, and certified patients were stigmatized due to the new voluntary category. According to Ramon (1983)<sup>15</sup>, ideas on the care of patients in the community expressed by this Act were largely left unimplemented by successive governments.

Just as in the First World War, when standards in the asylums deteriorated in the form of overcrowding because beds were required for the war-wounded and unavailability of experienced staff because they were required for the war effort, with the outbreak of the Second World War, existing shortages in mental hospitals were again accentuated. There was a regression in provisions for patients who could not contribute to the war-effort - out-patient clinics collapsed, hospital doors were locked and patients again became isolated and inactive.

#### THE MOVE TOWARDS A POLICY OF COMMUNITY CARE

##### The Mental Health Act (1959)<sup>16</sup>

Under the Mental Health Act (1959) the word 'mental' was removed from the name of psychiatric hospitals to emphasise that patients were on an equal footing with those in general hospitals. According to Unsworth, this Act combined the medical and social approaches by emphasising human relations. It logically belongs to measures introduced by the Labour Government 1945-51 which abolished the Poor Law and established the Welfare State by attempting to provide a legal framework for the achievement of a national psychological well-being without consigning recipients of care and treatment to the stigmatised status of certified lunatic. It was a negation of the 1890 Act and Victorian assumptions which had only been partially ousted by the 1930 Act by reorientating care from an institutionally-based system to community care.

Goodwin (1989)<sup>17</sup> argues that this Act was presented and has been accepted as a major reforming measure but, although



it emphasised the development of local authority services, it added few powers to aid such a change. It was not until the proposals of the Seebohm Committee (1968) were implemented in The Social Services Act (1970) that the responsibility for many aspects of community care was transferred away from local health authorities to social services departments, despite the protestations of many of the professionals involved.

Ramon also notes the ambiguities in the 1959 Act: it was presented as a breakthrough in adopting a community care approach but was also popular with proponents of the medical-somatic approach; it was regarded as progressive by both Conservative and Labour parties; and, although it added residential care to the brief of local authorities it left Clauses on community care as permissive legislation and the Government did not provide finance for its implementation. Further, the innovations which it spawned were unevenly spread over local authorities and there was also variation in the scope and quality of services. The major obstacles were difficulties in achieving team-work, differences in the quality and quantity of residential accommodation, lack of sheltered employment and isolation and deterioration after a short stay in the community.

#### The Influence of Drug Treatment

Jones describes the use of the 'chlorpromazines' (a group of drugs derived from phenothiazine), first developed in France in 1952 in the treatment of mental illness as the 'pharmacological revolution'. Psychiatrists and adherents of the medical model were optimistic about the new drugs which

were easy to administer and relieved the more disturbing symptoms making patients amenable to other forms of treatment. According to Unsworth, they also increased the credibility of psychiatry.

By 1955, these drugs were being widely prescribed in Britain. They produced a new calmer atmosphere in hospitals and, consequently, were accredited with creating the ideal conditions for the adoption of an open-door policy. However, since there had been several attempts to open hospital doors before the development of these drugs, albeit that they had been closed again due to public pressure, it can be argued that they merely helped maintain a pattern which was already established.

As a result of drug treatment, some patients could go home sooner and some people did not have to come to hospital at all. According to Jones, there was a strong link between the development of drug treatment, a cessation in the growth of mental hospital populations, a reduction in the number of inpatients and, consequently, the development of community care. F Martin (1984)<sup>18</sup> supports Jones' account:

*".... it is highly improbable that the discharge of long-stay patients could have been maintained or the length of stay of newly-admitted patients could have been brought down and kept down, had it not been for the efflorescence of psychotropic drugs....." (p2).*

Goodwin questions the association between psychotropic drugs and the development of community care policy by referring to inpatient populations in France which only began to drop in 1970. Warner also argues that the role of psychotropic drugs has been exaggerated by describing the improvement in discharge rates at Bexley and Mapperley

Hospitals by the end of the Second World War. Further, social therapies, far from being made possible by drug treatment, preceded and rivalled the psychotropic drugs in their impact on rehabilitation. Sedgwick (1982)<sup>19</sup> argues that it was active attention to rehabilitation and resettlement in progressive British hospitals which led to the swift and drastic reduction in the number of inpatients, considerably in advance of the introduction of phenothiazines.

### Ill-Treatment and Neglect in the Hospitals

If the primary aim of care is to cure or alleviate suffering and the secondary aim is to preserve order, it is easy to see how nurses working in the large mental hospitals opted for custodial care. Prevention of abuse was not a major policy issue in the 20th century because the beneficial role of hospitals had been taken for granted. However, the publication of *Sans Everything* (Robb, 1967)<sup>20</sup> and the *Report of the Inquiry into Allegations of Ill Treatment at the Ely Hospital* (1968)<sup>21</sup> made it impossible for policymakers to ignore the problem of potential abuse.

A letter to the Editor of the Times in 1965 registering shock at the treatment of geriatric patients which led to the publication of *Sans Everything* brought a new dimension to the anti-institutional movement because it contained specific charges against members of staff in hospitals for the old and mentally disordered. Although *Sans Everything* was partially discredited because of its vagueness, public concern was again aroused and its publication initiated a never-ending series of more precise allegations of ill-treatment and neglect which

were sensationalised by the press and led to enquiries and legal action.

In 1970, the Secretary of State Richard Crossman visited hospitals to see conditions for himself. He found that although individual nurses were responsible for their actions, understaffing, overcrowding and the poor material provision created such a low quality of life that the assignment of blame for cruelty and neglect were almost irrelevant. Further, allegations of cruelty against specific individuals resulted in hospitals being criticised indiscriminately and this destroyed the morale of existing staff and hampered recruitment of new staff.

In the early 1970s, there were a series of hospital enquiries which often led to police investigations and criminal prosecutions. J Martin (1984)<sup>22</sup> notes that they revealed cases of cruelty and neglect, inadequacies of provision, a lack of new thinking, the detrimental effect of professional isolation, low expectations of staff and patients, the danger of corruption in closed communities to the extent that staff and management could stifle criticisms, and the weakness of lay management to influence the quality of care.

Following NHS reorganisation in 1975, Regional and Area Health Authorities set up their own enquiries, for example, the Warlingham Park and Darlington Memorial Hospital Inquiries in 1976 and the Winterton Hospital Inquiry in 1979. These raised many of the issues of their predecessors but showed many differences. For example, ill-treatment was important but it was not the central issue, the internal enquiries had

failed because of a form of medical 'laissez-faire' and protection of the 'status quo', the focus had moved from management to the role of specific individuals, and it was not only the patients who suffered from being in isolated institutions - staff were also negatively affected.

According to J Martin, every inquiry hospital was geographically isolated, that is they were situated out of town in the tradition of the 19th century asylum. There was a tendency to form a closed community of staff and patients which increased stigmatization. Some wards were rarely visited by consultants and there was lack of support for victims of abuse probably because many long-stay patients did not have a large social network in the community which made it difficult to discover and report ill-treatment. Also sins of commission and omission could be rationalised - by denial of injury and responsibility and condemnation of the condemners. With the lack of properly-trained staff to deal with large numbers of difficult patients, coupled with failures of leadership and trade union problems, it is no wonder that there was 'corruption of care'.

However, the hospital enquiries were so 'traumatic' that many felt that the money spent on them could have been better spent on the hospitals under inquiry. Further, although recognition of a need, for example increased financial resources, is one thing but to will the means to meet it is another.

Nevertheless, they did contribute to a change in public attitudes, that is, from a rejection of the mentally ill and their containment in isolated institutions to their

reintegration in the community. They certainly allowed politicians to focus on the issue of community care in a broad and humane way. However, it can also be argued that it was the policy to close the mental hospitals which was partly responsible for abuses. For example, the running down of hospitals led to poor conditions and low expectations for staff and patients on long-stay wards. Most money was spent on admission and short-stay wards since the priority was to stop people becoming long-stay and this led to the 'back wards' being neglected. The best staff were attracted to new developments leaving the older more traditional and disillusioned staff to keep the long-stay wards going.

#### THE POLICY OF COMMUNITY CARE

##### Reactions to the New Policy

The new policy announcement, that the isolated mental hospital was to go and that in 15 years time most patients would not be treated in wards or wings of general hospitals, was made at the Annual Conference of the National Association for Mental Health in 1961 by the Minister of Health, the Rt. Hon. Enoch Powell in referring to the forthcoming *Hospital Plan for England and Wales* (Ministry of Health, 1962)<sup>23</sup>. It was based on a statistical analysis undertaken by the General Register Office and a projection on beddage figures which indicated a large and progressive decline in the numbers needed within this time period.

F Martin outlines how these mental hospital closure predictions depended on a social atmosphere which tolerated eccentrics and an economy which enabled them to be self-

supporting. They assumed that mental illness with all its distinctive features could be managed in general hospitals which reflects an over-simplified and optimistic view of mental illness. This meant that the new policy would, in practice, amount to no more than the transfer of the burden from trained to untrained staff, from the hospital to the community at large and the family in particular.

A technical report by Booth & Brooke (1961)<sup>24</sup> on the projection based on numbers occupying psychiatric beds 1954-59 seemed to validate the claims on which the new policy was founded. However, it stressed that although direction had been established, figures were temporary phenomena and could change. In particular, the rising population of old people susceptible to dementia could reverse this trend. This report also emphasised that the mentally ill could only become more self-supporting if the economic climate allowed and this was also an uncertain phenomena. Further the tendency to discharge the least dependent first might leave hospitals with a residue of difficult-to-place patients.

The reactions to the new policy were mixed - some enthusiastically welcomed the change whilst others were concerned about basing a 15 year forecast on a 5 year trend which contradicted previous trends. Also, it seemed that the successful discharge of patients would depend on how active the hospital's rehabilitation was and how satisfactory neighbouring community care services were. If these were inadequate and hospitals closed by administrative decision, then it would cause hardship for patients and their families.

Defenders of the hospital argued that work within the hospital was essential in preparing patients for the community and that the running-down of hospitals would lead to squalid conditions for those still housed there. For the psychiatric profession, the hospital provided assurance, whereas to venture into the community was to expose itself to challenges to its authority and threats to its status.

The new policy was supported by the political right and gained some unexpected support from the left from the anti-psychiatry movement, which gained notoriety through the work of Laing<sup>25</sup> (1960) and Szasz<sup>26</sup> (1961). Left-wing support increased on the publication of Erving Goffman's *Asylums* (1961) which mirrored the findings of Russell Barton in *Institutional Neurosis* (1959) - that long-stay patients had two illnesses, the one which had caused their admission and the one the hospital had given them. Goffman attacked the old-style mental hospital on the grounds that it was a 'total institution' and, as such, erected an impermeable barrier between the inmates and the outside world.

Jones (1988)<sup>27</sup> notes that critics of society like Goffman, Laing and Foucault, saw discharge from hospital as the answer to patients' problems. However, if it is society that caused their problems in the first place, then how could a return to society, or the 'community' solve them? Further, the policy of community care was based on the assumption that everybody lives in a geographically defined community, members of the community live in continuous interaction with each other, communities exist by consensus and social exchange, communities have strengths which can be utilised for assisting



their weaker members, and community support is more flexible and caring than that of official agencies. In reality, however, communities are difficult to define and they will not be caring if their inhabitants are motivated by profit and are suspicious and frightened of anything eccentric.

Busfield (1986)<sup>28</sup> and F Martin both attribute the policy of community care to the development of a consensus of enlightened opinion among policymakers, psychiatrists and the public in the post-war period in that they all regarded the old asylums as out-dated relics albeit that they disagreed about the speed at which they should be closed, what exactly should replace them, and the means of financing community services.

Goodwin disagrees that this policy was a reformist measure resulting from enlightened thinking. Instead it was a response to a crisis in institutional care - hospitals were overcrowded and in a serious state of disrepair, the institutional system of care had failed to increase its capacity to meet demand and was inappropriate for modern methods of care and treatment. Therefore, this policy provided the rationale for reducing the length of time patients spent in hospital and avoiding the expensive refurbishment of the old asylums.

Scully<sup>29</sup> (1984) agrees with Goodwin that there had been a breakdown in institutional care. He outlines how the shift to community care in the UK in the late 1950s was not due to the introduction of drug therapy, or a response to sociological critiques of the mental hospital, but a strategy for averting an escalating crisis of overcrowding and underfinancing

stemming from the need to invest on a massive scale to replenish and modernize the nation's stock of 19th century mental hospitals. Thus, the motivating force behind deinstitutionalisation was the desire by right-wing politicians to develop welfare programmes which would allow the indigent and disabled to be maintained more cheaply and avoid a fiscal crisis of the State. Sedgwick disagrees - he argues that decarceration preceded the fiscal crisis proper and that a comparative analysis indicates no automatic relationship between the two.

According to Scull, the commitment shown to a policy of deinstitutionalising deviant populations was due to the idea that community treatment was not only cheaper but more humane and effective. However, he noted that this had not been proven - community care may not be cheaper if it is adequately funded and there is the danger that people will end up in communities which are least able to care for them. Institutions offer the community protection from the deviant and the deviant protection from the community in the form of 24 hour care with full board and lodgings and 'asylum', that is, a place of safety. Given the cuts in community services, it was unlikely that the community could carry out all the functions of the mental hospital, therefore, institutional care is better than nothing. Scull (1984)<sup>29</sup> concludes that *"..... community care is an ideological camouflage, allowing economy to masquerade as benevolence and neglect as tolerance ....."* (p152-153).

Nevertheless, decarceration appealed to all - for the left, it was compatible with themes of the Welfare State with

the emphasis on the effect of the social environment and a need to treat the disadvantaged with paternalistic tolerance. For the right, and especially those against excessive spending on welfare measures, it promised economy in public spending.

Warner (1985)<sup>11</sup> notes that deinstitutionalisation may be a sign of progressive efforts towards community care and rehabilitation but it may just as easily represent the abrogation of responsibility for the welfare of a segment of the poor. His summary of the possible political motives has many parallels with other authors: cost savings; humanitarian concern for the welfare, liberty and human rights of institutional inmates which outweighs the fear of their liability to the community; and, a need to put the inmates to a new purpose due to the demand for labour in post-war Britain. He concedes that cost savings is an important factor but also argues that humanitarian concerns have never been a sufficient cause for change. (p91)

#### Commitment to the Policy of Community Care

GPs could have been the focal point for services for the mentally ill in the community but F Martin demonstrates how GPs in the 1950s had shown little interest in community-based psychiatric care. This may have been because they had had little psychiatric education, doctor-patient relationships were becoming increasingly depersonalised, and they would only be able to treat the symptoms of mental illness with drugs.

Warner (1985)<sup>11</sup> highlights evidence of the inadequacy of community care provisions in England & Wales. The number of mental patients admitted to hospital who had 'no fixed abode'

had increased threefold between 1959 and 1964. By 1966, 10% of the 30,000 people sleeping rough were thought to be suffering from mental illness. At the same time, concern was developing over the increasing numbers of mentally ill criminal offenders who were committed to hospital or incarcerated in prison or borstal. (p89)

The Seebohm Committee (1968) noted that despite a national commitment to community care and official plans to run down the number of mental health beds, local authorities only devoted a small fraction of their total health service budget to the mentally disordered which was unevenly distributed leaving many needs unmet.

The Conservative Government which came to power in 1970 confirmed and accentuated the policy trends of the 1960s: integration of psychiatry with general medicine; reduction of hospital beds; development of day and out-patient facilities; and, a shift in responsibility for residential and social care to the local authority. A Circular published in 1971 entitled *Hospital Services for the Mentally Ill* also confirmed the Government's proposals - complete abolition of the mental hospital system within 15-20 years by which time all provision would be based in the District General Hospitals.

However, the White Paper *Better Services for the Mentally Ill* (DHSS, 1975)<sup>30</sup> pointed to the decline in interest in rehabilitation, and also discharge policies which took no account of the availability of supporting services. It openly acknowledged the shortcomings of local authorities and central government with regard to community care.

*"Those who work in the health and social services fields have to recognize that families and relatives, and indeed the public at large cannot be expected to tolerate under the name of community care the discharge of chronic patients without adequate arrangements being made for after-care and who perhaps spend their days wandering the streets or become an unbearable burden on the lives of their relatives; hostels which are so selective that they are only half full while people needing residential care are told they are unsuitable; appeals which go unanswered for help in crises while authorities or professional officers debate boundaries of responsibilities." (DHSS, 1975, para 2.27)<sup>30</sup>*

Its broad policy objectives were the expansion of local authority personal social services, relocation of specialist services in local settings, establishment of 'right organisational links' within and between health services and local authority social services, significant improvement in staffing to allow for prevention, early intervention, and multi-professional assessment and review. These were in line with the gradual implementation of a community care perspective but, according to Ramon, its main recommendations did not call for the investment of additional money, only the reallocation of the sums already available.

Resident hospital populations were declining but the number of admissions, especially readmissions, were on the increase so the 'open-door' was really a 'revolving-door'. Local authority social services departments were expanding residential and day services with extra support from joint financing, but the differences between local authorities continued, for example the inner London boroughs spent twice as much as the others. Warner notes that in 1976, only 43% of the recommended minimum number of places in hostels and group homes had been established, day facilities were more scarce and some local authorities had provided nothing at all. Ramon

notes that community care programmes were not as cheap as they were expected to be and that by 1978, there was still more investment in hospital beds than hostel places.

The Report of the Royal Commission on the NHS, the *Merrison Report* (1979)<sup>31</sup>, was critical of the response of District General Hospitals to mental illness and voiced disappointment in both the pattern of hospital care and the creation of services for the mentally ill in the community by local authorities. However, it was ambiguous about what the balance between hospital and community care should be. For example, it argued that Health Departments should make it clear that there was a long-term future for all mental hospitals unless they were isolated or dilapidated. However, it also added that: *"We think it right that the emphasis should be on the development of community services although progress will be restricted"* (Merrison Report, 1979, para 6.3)<sup>31</sup>.

The Conservative Government of 1979 was dedicated to two principles potentially relevant to the development of community mental health services - an overriding commitment to reduce public expenditure and the burden of taxation, and counteraction of the long-term trend of local authorities towards over-dependence upon, and excessive regulation by, central government. By this time, the Inner London local authorities had reached the guideline figure as far as residential provision was concerned and three (Islington, Tower Hamlets, and Newham) had reached the recommended level of day-care. However, a handful of local authorities had still created no hostel or other residential services, and

many had made no direct provision for day-care. This may have been because local authorities had to please a public that did not consider the mentally ill to be a high priority.

The document entitled *Care in the Community* (DHSS, 1981a)<sup>32</sup> suggested some specific ways of removing existing obstacles to the transfer of resources from health authorities to the personal social services to enable people who did not need to be in hospital to be moved into the community. According to F Martin, its most valuable proposal was to introduce greater flexibility into arrangements for joint finance so that District Health Authorities could make lump sum payments or continuing grants for an unlimited period to local authorities or voluntary organisations to provide services for identified persons moving from hospital to community care, and vacancies in facilities supported in this way could be filled either by new discharges from hospital or people who would otherwise have required hospital admission.

Responses to this document were analysed and led to a number of ministerial decisions set out in *Health Services Development: Care in the Community & Joint Finance* (1983). However, Ramon notes that joint finance arrangements were only for an initial period and, given the economic climate, they were not, in practice, an incentive for local authorities to initiate new services. These new proposals had also referred to the handicapped and the elderly so it was unknown how much would be allocated to provisions for the mentally ill - it would obviously be attractive for local authority social services departments to provide community-based services for mentally handicapped children. Another restriction on these

proposals were that they focussed exclusively on the transfer of long-stay patients.

The document entitled *Care in Action* (DHSS, 1981b)<sup>33</sup> touched generally on the key problems of the statutory services and their links with the voluntary and private sectors. It emphasised the statutory obligation on health and local authorities to secure and advance the health and welfare of the population and the importance of enabling as many frail elderly, mentally ill and handicapped people to live in non-institutional settings. With regard to the mentally ill, it acknowledged that uneven progress had been made by local authority social services departments in providing maintenance, support and rehabilitation facilities, and that an understanding of the personal and family problems involved and a knowledge of relevant community resources were more important than large financial resources. This document offered clearer guidance, albeit a rather negative view on the future of the mental hospitals - if they could provide a service reaching out into the community, they should be closed in the next 10 years or so, and their resources should be redeployed into the new pattern of health services. Generally, however, it merely set out familiar objectives and suggested modifications - it did not provide much in the way of original ideas for the achievement of desirable ends.

### The Voluntary Sector

Since the concept of community care depends on encouraging collaboration between services especially those with local roots and voluntary organisations, the force with which the



voluntary sector tried to implement community care is an important consideration.

The Mental After-Care Association has long been concerned with the rehabilitation of patients discharged from mental hospitals. It now owns or leases all its homes and hostels and works with health authorities, social services departments and housing associations to provide a wide range of services in the community for people with mental health needs and their carers in southern England.

The Richmond Fellowship was founded in 1959 when it opened its first halfway house in Richmond, Surrey. With the closure of larger mental hospitals and the move towards community based mental health services, it has grown to meet the needs of people with mental health problems. It now runs halfway houses and therapeutic communities all over England and Wales. Its commitment to providing its residents with a high quality of life is reflected in its relentless pressure on national and local government for community care to be properly supported.

Following a debate in the House of Lords on the mental health services (31.3.81), the Richmond Fellowship set up an enquiry, chaired by Lord Longford, into the community approach to the mentally ill. The *Report of the Richmond Fellowship Enquiry* (1983)<sup>34</sup> was very critical of the age-long and continued neglect of the mentally ill and the erosion of the institutional base of the mental health service without the construction of a new one. It deplored the use of the term 'community care' (p24), a slogan which diverted attention from the real issue - the quality of life of the mentally ill. The

Report also noted the lack of knowledge of mental illness, its management and advocacy training, and that there had been a neglect of the principles and practice of community care in the training of psychiatrists and GPs.

This Report contended that if it was government policy to ensure good quality provision, this must be made mandatory. This would involve additional finance and the establishment of appropriate local machinery to identify needs, provide specialist services, ensure that community provisions are accessible and feasible, and help to raise the level of public understanding, sympathy and cooperation. It recommended that a Minister be appointed to ensure that a wide spectrum of community services are available and that a Fund be specially earmarked for this purpose in parallel with joint funding arrangements - the cost should not lie with local authorities.

The National Association for Mental Health was founded in 1946 and in the 50s and 60s it built up a substantial and varied programme of activities: direct services; public information and advice; professional education; and, the development of local mental health associations country-wide. According to F Martin, it was initially an 'establishment' organisation which kept a low profile and worked closely with the relevant professions and government departments. However, as early as 1959, it was voicing its own opinions by arguing, albeit quietly, that it was essential that local authorities were required, rather than just encouraged, to provide psychiatric after-care facilities.

In the 60s, as consumer movements became increasingly active and conditions in mental hospitals came under increased

criticism, it began to adopt a more critical stance although it was not until the early 70s, under its new name MIND, that it had a decisive change of identity. Its new Director Larry Gostin was recruited from the National Council of Civil Liberties and, under his leadership, the emphasis was on pressure group activities. It was in the field of legal rights, that is the status of psychiatric patients, that MIND caught public and professional attention. There was a detailed and continuous critique of the workings of the 1959 Act especially sections which gave compulsory powers to doctors and restricted the rights of detained patients, on the grounds that they were an infringement of civil liberties. (Gostin, 1975)<sup>35</sup>

By 1982, MIND had 168 local mental health associations, which may be seen as a measure of the growing public awareness and concern for mental health matters. The largest area of activity by local associations has been in providing accommodation schemes, with an emphasis on small scale group homes. In 1983, they were responsible for more than 300 schemes providing 1600 places. They also ran 195 social clubs and 66 day centres. Other activities included mutual aid and support groups for people with specific problems, and relatives, and counselling and befriending schemes.

Under the leadership of Larry Gostin, MIND campaigned increasingly for mental patients' legal rights by asserting the autonomy of patients against professional psychiatric power and demanding the enhancement of their civil and social status, for example, via extension of voting rights and representation at Tribunals. It published a Report entitled

*Common Concern* (MIND, 1983)<sup>36</sup> which was described as a Manifesto for a new Mental Health Service. This Report summarized recent trends in services, noting the rigidity of roles in existing professional groups and warning against strict adherence to community care concepts because they did not provide an adequate foundation for comprehensive services. It argued that hospital admission would still continue to be necessary for some people and that the severely disabled would still need 'asylum'.

According to this Report, the objective of change should be the creation of an improved quality of care. The justification for community-based services should be that they provide more effective care. Formal care should be provided in the least segregated or restricted environment, it should be based on the requirements of individuals and enhance their status as citizens, and support the informal sector. According to F Martin, the most valuable feature of this Report was its firm adherence to the principle that all planning of services should be built upon a detailed assessment of the needs of consumers and potential consumers and should be responsible to changes in their needs. However, it did not offer suggestions on achieving these principles.

MIND can take a large share of credit for the Mental Health Act 1983 and significant changes in the legal position of psychiatric patients. The price that it had to pay was that psychiatrists no longer regarded it as a friendly critic but an enemy and its aggressive campaigning style had alienated many more former allies. It has experienced problems in its relationships with statutory services and in

balancing the input of clients and others in the control of the organisation as well as in obtaining financial support.

The potential of all voluntary organisations is limited by their precarious financial position. They receive grants from the Department of Health, and contributions from health and local authorities, but their attitudes vary, so without generosity in the public sector, the innovative work of the voluntary organisations is crippled and the consequences for the mentally ill, especially with the move to close the larger mental hospitals, is serious. Further, the services provided by voluntary organisations are local, spontaneous and sporadic so they cannot be expected to be a vehicle for national policy although they could be emulated by statutory services.

#### The Mental Health Act (1983)<sup>37</sup>

This Act restored formal legal safeguards to a central place in legislation and two thirds of its reforming provisions derive from proposals advanced by MIND in *A Human Condition* (Gostin, 1975)<sup>35</sup>. According to Unsworth, it constituted a considerable 'revival of legalism' without stigmatisation. Further, the political and theoretical foundations of the new legalism which characterised the 1983 Act were to be found in the anti-psychiatry movement, in the writings of authors such as Laing, Szasz, and Goffman.

The manifestation of legalism in this Act were seen in the introduction of safeguards to restrict the powers of the psychiatric profession, the general reduction in immunities from suit in respect of the exercise of psychiatric power, and

the statutory extension of franchise to greater numbers of informal patients.

Under this Act, long-term compulsory detention could no longer be used for the purposes of preventative custody - the purpose of detention must be therapeutic. This Act also accorded non-medical professions increased recognition and prestige in care, treatment and decision-making processes. The principal beneficiaries were social workers and clinical psychologists although it was questionable how much power they would have, in practice. Nurses were granted an unprecedented recognition in being given the power to detain patients which added to the custodial aspect of the nurse-patient relationship and which consequently might have a negative effect on their role in preparing patients for discharge to the community.

This Act was seen as enshrining the concept of patients rights with regard to treatment. Although the relationship between the power of psychiatrists to administer treatment and the rights of patients to withhold consent was not clearly defined, it was generally assumed that the position on consent would depend on the type of treatment - patients would have the right to resist irreversible and hazardous treatments, for example, psychosurgery required the 'valid' consent of the patient and a second opinion. Under this Act, patients also have the right to treatment and services and Section 117 stipulates that they should be treated in the 'least restrictive alternative' and that District Health Authorities and local authority social services departments, in

cooperation with voluntary agencies, have a duty to provide care in the community.

### MODELS OF MENTAL ILLNESS

Radden (1985)<sup>38</sup> describes how the religious understanding of madness whereby the devil deprived people of their reason was replaced by the medical model whereby madness is seen as analogous to physical disease. As the insane were perceived as 'ill, moral blame was lifted, it was not their fault they had become sick and, consequently, they were not responsible for crimes they committed because they were mad. Thus, the medical view of madness led to the legal use of insanity as a defence of wrongdoing. The link between the medical model with its function of removing culpability in legal terms justified and supported its adoption in preference to other models although it has not gone unquestioned. The anti-psychiatry critique of the medical model has been unremitting since the writing of Laing and Szasz who argued that it rests on a false ideology, madness is caused socially, not biologically or chemically and the classification of madness as opposed to illness or disease is based on a normative judgement.

Ramon notes that as medicine began to cure mass illnesses, the prestige attached to the medical profession increased and the accepted model of explanation and intervention for mental illness became the medical-somatic one. However, the medical-somatic and community care approaches are conceptually incompatible in terms of their understanding of mental illness, intervention and the

structure of the care system. This incompatibility was not recognised by the different professional groups concerned with implementing a policy of community care. By retaining the medical-somatic model, they did not have to question the existing social order. Community care was merely equated with treatment outside hospital but nobody came up with the conceptual or organisational framework for its implementation. The only new model to emerge was the anti-psychiatry model which differed from both the medical-somatic and community care models, although it shared something with the latter. It was, however, politically related so it was the medical-somatic and community care models which remained as social policy alternatives.

Jones (1972)<sup>5</sup> views current development as a mixture of the Medical and Seebohm models. Under the Medical model, hospital services are of prime importance, social work is ancillary to medicine, and psychiatry has to fit in with the traditions of general medicine. Treatment in the District General Hospitals provides the mentally ill with an efficient and convenient service. The Seebohm model identifies mental illness and handicap as primarily social problems demanding skills in social diagnosis and human relations. The view of mental illness put forward by Szasz had few supporters in psychiatry but many in social work and advances in this profession may lead to the predominance of the Seebohm model in community care. However, Jones also views current development as being in danger of slipping into the No-Model model. In this view of society and medicine, there is no place for mental illness as outlined in Laing's projection of



the problem onto other people and Goffman's idea that there is no problem. If this model predominates, then some people may not get the help they need.

## CONCLUSIONS

As outlined in the Introduction to this Chapter, from this presentation of the different interpretations of the history of the mental health services in England and Wales under a number of broad headings, the researcher identified a number of recurring themes which had important implications for her own study of the closure of Friern Hospital and the provision of care in Islington and also, ultimately, for the future care and treatment of mentally ill people in general.

### Stigma

The stigma attached to mental illness and to people who suffer from mental illness is a recurring theme in the history of the mental health services. It has its roots in the early perceptions of madness as unreason and evil and is important because of its influence on how mentally ill people have been, and continue to be, treated.

### Harsh Treatment and Neglect

The harsh treatment and neglect of mentally ill people is a another recurring theme in the history of the mental health services and this also has roots in the early perceptions of madness. Unless the perceptions of madness as unreason and evil can finally be eradicated, mentally ill people will continue to be neglected and harshly treated in the community.

## Fear

Another important theme to emerge in the history of the mental health services is fear. There is a general fear of mental illness because of the resultant loss of financial and social standing and control over one's own life. This fear is increased if mental illness is considered to be incurable because incurable diseases breed their own fears of contagion and hereditability.

There is also fear of mental illness because of the early perceptions of madness as unreason and evil which, although began to be eroded with a change in the perception of madness to one of mishap, has never quite lost its link with the 'unnatural'. This is particularly true of the behaviour which is a symptom of schizophrenia, which was discussed in Chapter 5, and which leads to a fear of what the mentally ill may be capable of.

There has always been a fear by those in power of any threat to social order and this increased after the French Revolution. Therefore, mental health legislation may be regarded as a reaction to fear and an attempt to control mentally ill people.

Psychiatry was born in the asylum, so it is understandable that psychiatrists may have a fear of leaving the hospital, the place where their prestige and status went unquestioned, for the community, a relatively unknown environment where they must share their power with other professionals.

The mentally ill must historically have had a fear of confinement against their will, harsh treatment, and neglect.

They may now have a new fear - a fear of returning to a community where their problems arose or moving to an unknown community where they have no 'asylum' - a place of safety.

A climate of fear, whether it is public fear of mental illness and mentally ill people, professional fear of loss of prestige, or the fear of mentally ill people of inadequate care is clearly detrimental to the successful implementation and sustainment of a policy of community care.

### Inequality

Inequality in the care and treatment of mentally ill people is another feature of the history of the mental health services. In the 17th, 18th and 19th centuries, this tended to be between the rich and poor whereas in the 20th century it has been between health districts and local authorities. However, with the closure of the large mental hospitals, the differences between the rich and poor may again manifest themselves in that if there are inadequate facilities in the community to care for all people suffering from mental illness, especially in times of crisis when hospitalisation would previously have been the solution, it will only be wealthy people who will be able to pay for a hospital bed - others may be left to wander the streets unless they bring themselves to the attention of the police when prison could be the outcome.

### Low Status and Priority

Throughout the history of the mental health services there is always the sense of the low status and priority of the mentally ill.

For example, legislation in the 18th and 19th centuries which, for example, separated the insane in Workhouses and Prisons and protected against illegal detention was for the benefit of the sane. The low status and priority of mentally ill people was also seen during the First and Second world Wars when their beds were commandeered for the war-wounded, staff for the war-effort and there was a general cessation in services for people who could not 'contribute'.

There are many more examples of the low status and priority of mentally ill people. The *Mental Health Act* (1959)<sup>16</sup> was far behind other reforming measures which were part of the architecture of the Welfare State. Voluntary organisations rather than statutory organisations have consistently led the way in innovative and humane care of mentally ill people and in campaigning for their rights. There has been inequality in the provision of services for mentally ill people between local authorities with some local authorities providing very little. This is because local authorities have to balance their statutory responsibilities with client-led demands, and they have to appeal to their public. Since mentally ill people find it difficult to make their demands heard and are not so appealing to the public as other needy groups, they are, therefore, often a low priority for local authorities. Also, there has been a continued reluctance at a central government level to allocate adequate financial resources for the care and treatment of mentally ill people.

The lowly position the mentally ill have occupied on the social welfare priority ladder lends credence to Herbert

Spencer's principle of 'the survival of the fittest'.

Allocation of resources reflects a hierarchy of social evaluation in which those persons deemed to be less fit and capable of surviving are placed in the lowest categories of provision and esteem. Evaluative criteria of competitive individualism may no longer be so explicit as they were in official Poor Law directives but these values are, according to Pinker (1971)<sup>39</sup>, still put in practice whether by default or intent, although not now with official approval or acknowledgement of their theoretical origin.

If community care is to be successful, there must be evidence that mentally ill people have been elevated from their lowly position on the social welfare priority ladder and treated 'as equals'.

#### Policy for Mentally Ill People - Ambiguities, Conflicts and Lack of Consensus

An historian might see the following schema of progression in policy for mentally ill people: their internment with other social deviants; their progressive separation from other internees; the establishment of asylums for their exclusive internment; the emergence of psychiatry for their treatment; and, their deinstitutionalisation. This may give the impression that mentally ill people have been the central characters in changes in policy but, although they have been affected by all these changes, they have not been the subjects of their own history and their welfare has not always been the primary motivating force.

As already discussed, legislation for the mentally ill in the 18th and 19th centuries was often for the benefit of the sane. This highlights the important influence of public knowledge and concern on policy for the mentally ill. For example, the public's knowledge of King George III's illness led to the conception of madness as a mishap and gentler treatment. The Royal Commission (1924-26) was appointed because of the public's uneasiness at the large number of allegations of wrongful detention and widespread cruelty and bad administration in institutions for the mentally ill. The hospital enquiries of the 1960's, 70's and 80's were the result of allegations of abuse brought to their knowledge, usually via the press.

However, the influence of public knowledge and concern on policy does not necessarily change how the public act in reality towards mentally ill people. The public have historically had negative attitudes towards mentally ill people - fear, condemnation, lack of interest, and apathy, and there is no real evidence of the public displaying greater sympathy or tolerance. The public cannot learn from their GP's example and the idea that the mentally ill should be free and live as part of the community may not be so attractive when the public reflect on who is going to pay for this and where they are going to live. Rationality and kindness may be replaced with a less enlightened approach the closer the subject is to the interest of particular individuals or communities.

Legislation for mentally ill people has also been affected by the prestige of different professions over time

and has, in turn, endowed these professions with enhanced status - law, medicine, and more recently social work. Therefore, different professionals have had a vested interest in supporting particular trends in policy. This is also true of individuals such as Dr John Conolly, or particular schools of thought such as the anti-psychiatry movement - policy trends have legitimized their opinions or served as a focus for criticism but both have enhanced their authority and 'careers'.

The cost of care and treatment has consistently been an important influence on policy. For example, it was cheaper to keep the insane in asylums than Workhouses, moral treatment was popular because if the insane could be cured they would cease to be a drain on the public purse and, more recently, it has been assumed that community care is more cost-effective than hospital care especially in view of the huge cost of maintaining and upgrading the large mental hospitals.

This preoccupation with financial concerns is largely a product of political motives. However, politicians have consistently paraded their policy objectives as also being the products of enlightened thought and humanitarian concerns. Also, there has been no clear divide between the main political parties on recent legislation. For example, there was ambiguity in the 1959 Act in that it appealed to both proponents of the medical model and the community care approach, and both the Conservative and Labour parties considered it to be progressive - it was all things to all men.

Both Conservative and Labour Administrations have embraced the idea of community care albeit to satisfy different political ends, but there has been a lack of clarity and specificity in formulating objectives. There have been calls for cooperation but little guidance as to the processes and structures required to achieve this. There has been verbal but not practical or financial commitment by central government to implementing the policy of community care. Indeed, it has not even been clearly defined.

Historical evidence suggests that humanitarian concerns have not been a sufficient motive for changes in legislation. Inadequacies have been noted and reforms suggested only to be swept away in the light of more important considerations and priorities. Allegations of ill-treatment and neglect have arisen again and again and it has only been when public concern has been sufficiently aroused that these have been investigated. Enquiries, however, are only a means to an end, they cannot in themselves constitute that end. Listing the reasons why abuses have occurred, disciplining the main offenders, noting the inadequacies in services, and changing the venue for the care from the hospital to the community will not ultimately benefit mentally ill people unless central government is dedicated to this purpose in terms of guidelines and finances.

With regard to services for the mentally ill, the emphasis has always been on legislative and administrative development and there has been little concern for the human dimension, that is, the mentally ill and their relatives.



The mental health services emerged out of general provisions for social misfits in the 18th century to the building-up of a highly distinctive tradition in the 19th century and then a shattering of that tradition in the 20th century. When there was no particular legislation for the mentally ill, they were in a sense, integrated in the community. With the move to a policy of community care, attempts are being made to integrate them again. Thus, the pattern of care so far has been integration, separation, integration.

When there was no specific policy for the mentally ill, they were detained in Workhouses and Gaols. As outlined in Chapter 5, today many are to be found in the modern-day equivalents - on the streets and in Prisons. This is already arousing public and professional concern and if this situation goes unchecked, the result of the policy of community care may be another period of separation for the mentally ill.

The move to a policy of community care does not constitute what Kuhn (1962)<sup>40</sup> describes as a 'paradigm shift'. If institutional care is taken as the old paradigm and community care the new competing one, it is true that they are different and incompatible, and that the competition between them reflects divergent conceptual relations. This is, however, where similarity with this analogy ends. Institutional care came under threat from various quarters, for example, anti-institutional and anti-psychiatry movements; 'new' professionals who had very little power and status in the existing regime of care; organisations such as MIND who were concerned about the welfare of patients; and, politicians

who assumed that community care would be cheaper than modernizing the large old-style buildings.

It was not true, however, that institutional care was no longer considered by anyone to be the answer to the problem of caring for mentally ill people. Many believed that hospital care was the best and most humane solution. Some professionals, especially psychiatrists, have had a vested interest in campaigning for the retention of the institutional base. However, others who have been concerned for the welfare of mentally ill people have opposed closure of large mental hospitals on the grounds that the assumptions upon which community care had been based were false or untested.

The policy of community care may have been based on false claims, for example, the effect of drug treatment, and projections on beddage. It may also have been primarily instigated for financial rather than humanitarian concerns. This does not mean, however, that it is the wrong policy although the rationale on which any idea is based is likely to affect its practical application and, of course, its outcome.

Therefore, it was not true that all proponents of the two competing 'paradigms' were 'living in different worlds', that institutional care had been completely discredited and community care was considered to be superior, and that the policy of community care constituted a 'paradigm shift'. Since everyone working, or with an interest, in the mental health field did not initially support this policy, it is unlikely that everyone has put all their efforts into implementing it, and has rallied round to defend it from

public criticism. This must obviously have had a negative effect on the outcome.

### The Importance of these Themes for this Study

The afore-mentioned themes were very important for this study in that they 'informed' the research questions outlined in Chapter 1. They showed the importance of focussing on the experience of patients and ex-patients, that is, making mentally ill people who have 'historically' been stigmatised, treated harshly and unequally, neglected, feared, and been of low status and priority, the 'subjects' of research. This meant placing priority on what they had to say and evaluating the Friern closure programme and community care in Islington from the perspective of the welfare of patients and ex-patients.

Friern Hospital was a concrete example of mental health policy in England and Wales for 150 years. It had been 'home' to the 'subjects' of this study and, as such, their lives were inextricably linked to the hospital and affected by it. Therefore, these themes also served as a point of reference for the history of Friern Hospital and its closure which is the subject of Chapter 7.

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## CHAPTER 7

### FRIERN HOSPITAL

#### INTRODUCTION

As outlined in Chapter 1, when Friern Hospital opened on 17th July 1851 as Colney Hatch Pauper Lunatic Asylum, it was hailed as Europe's largest and most modern institution. When NETRHA announced its intention to close Friern in 1983, there were some who could not wait for the bulldozers to appear, and equally as many who mourned its imminent demise.

This Chapter is divided into two parts. Part 1 is concerned with the 'history' of Friern Hospital prior to the closure announcement and Part 2 focuses on the closure of the hospital.

The researcher decided to highlight these two areas for three main reasons. Firstly, Friern Hospital had been 'home' for many long-stay patients for a very long time. This meant that their lives were inextricably linked to the hospital and affected by it, no more so than when the closure decision was made because of the rationale behind the decision, the unfolding of the closure programme, and the resultant effects on the care of long-stay patients in the community. Secondly, Friern Hospital had been the place where the majority of Islington residents suffering from mental health problems had, for many years, been confined and treated for short and long periods, so people living in Islington would have 'inherited' an image of the hospital and its patients which may affect how they would be received in the community. Thirdly, Friern Hospital had been a

concrete example of mental health policy in England and Wales for almost 150 years, thus placing this particular research in a wider historical context.

All the material presented in Part 1, unless otherwise referenced, comes from two sources: the very graphic account of the history of Friern Hospital in the Centennial Edition of the Friern Hospital Magazine (1951); and, R Hunter & I Macalpine's *Psychiatry for the Poor: A Medical and Social History* (1974). The afore-mentioned authors studied all the historical material relating to Friern Hospital, for example: Reports of Select Committees, Commissioners in Lunacy, Committees of Visitors, and the London County Council (LCC); Health Board and Authority Records; the Hospital Register; and, Case Histories of Patients. The material presented in Part 2 comes from a variety of sources with an emphasis on policy documents and interviews with some of the professionals listed in *Appendix 4.1*.

Thus, this Chapter represents both the end of the Literature Review and the beginning of the presentation of Findings in this thesis. Since this Chapter does not repeat information given in the section on Friern Hospital in Chapter 1 (p13-16), and the TAPS findings with regard to long-stay patients in Chapter 3 (p62-66), reference should also be made to these Chapters and the relevant *Appendices* (1.1 - 1.7) to gain the 'total picture' of Friern Hospital and its closure, on which the Conclusions to this Chapter are based.

## PART 1 - THE 'HISTORY' OF FRIERN HOSPITAL

### Reason for Construction

In 1847, there were 2,400 known cases of pauper lunatics in Middlesex and the Middlesex Pauper Lunatic Asylum at Hanwell in West Middlesex (now St Bernards Hospital in Southall) which had opened in 1831 could only cater for 1,000. This meant there were large numbers of pauper lunatics in Workhouses, Prisons, Houses of Correction and other places of detention and restraint who were being neglected and maltreated.

The proposal to double the size of Hanwell was rejected on the grounds that it would make individual patient care impossible and exercise and employment problematic. This led to the building of Colney Hatch Pauper Lunatic Asylum in East Middlesex to care for quiet chronic incurables which would be less expensive than maintaining them in places of detention which had no facilities for them and could be run on much cheaper lines than Hanwell which would be free to 'cure' the more recent and milder cases in the county.

### Changes in Finance, Administration and Name

When it opened, Colney Hatch was financed by Middlesex County Council (MCC). It was administered by a Committee of Visitors selected by the Council and inspected by fully-salaried Commissioners appointed under the Lunacy Act 1845. The first patients were quickly sent to Colney Hatch from workhouses and private asylums in East Middlesex because the cost of maintenance in these establishments was the most expensive and Colney Hatch had to be full to pay for its



upkeep. The MCC had to provide for the largest number at the lowest cost to compete with the parish workhouses, and in 1852, the asylum's first full year, the weekly rate per patient (8s 2d) was charged to the Board of Guardians of their parish of origin.

The Local Government Act 1888 transferred large areas of Middlesex to the newly-formed London County Council (LCC) and in 1889, it became a London County Asylum. The Committee of Visitors appointed to manage the asylum for the LCC were middle-class Justices of the Peace, living in respectable suburbs such as Highgate and Finchley, therefore their social situation was far above and removed from the patients with whose care they were entrusted. They tried to maintain a balance between their duty to the rate-payers and the patients by being economical in satisfying the latter's needs - they did not provide comforts considered 'luxurious' for this class of patients because if they recovered and returned to their former condition, they would suffer distress at the absence of comforts they had come to accept as 'necessities'. Until the First World War, the LCC managed to keep the cost of patient care at around 10s per week. After the war, the cost of patient care doubled in line with the general rise in the cost of living and wages.

Under the Mental Treatment Act (1930) Colney Hatch Asylum became a Mental Hospital, the lunatic became a patient, and the pauper became a rate-aided person. In 1937, Colney Hatch was renamed Friern Mental Hospital to further remove the prior association with the Poor Law, and under the Mental Health Act (1959), the word 'mental' was

removed to emphasise that patients were on an equal footing with those in other hospitals.

During the Second World War, Friern's catchment area was Finsbury, Hampstead, Holborn, St Marylebone, St Pancras and Shoreditch. When the NHS Act (1946) came into operation in 1948, Friern Mental Hospital, like all hospitals, was absorbed by the Ministry of Health. Friern was now supported by central government instead of county funding, came under the authority of a new Regional Hospital Board (North West Metropolitan), and was allotted catchment area responsibility for three North London boroughs (Camden, Islington, and Haringey). It was administered by a locally-constituted Management Committee.

The North West Metropolitan Regional Board, like other Regional Boards, had limited resources to maintain old buildings and mental health services remained a low priority. There was, therefore, continued pressure to keep the cost of patient care at Friern down.

In 1967, the management of Friern's services was the responsibility of three Health Authorities: Camden, Islington, and Haringey. When the NHS was reorganised in 1974, the management of Friern Hospital was taken over by NETRHA with local management by Islington Health District until 1982 when Hampstead became the managing authority. The cost of patient care had risen to thirty pounds per week as compared with ninety pounds per week for a patient in a general hospital. (UCL, 1987, p1)<sup>1</sup>

### Demand for 'Asylum'

Colney Hatch was originally designed to take 1,000 patients but was enlarged while being built to accommodate 1,250. By 1856, there were 1,000 lunatics in Middlesex still requiring 'asylum'. The Commissioners were opposed to a further enlargement because it would be more difficult to manage, treat, and supervise a larger population of patients. However, due to the high cost of building a third asylum, work began on two new blocks and single storey wards at Colney Hatch providing 700 additional beds. However, the resultant respite that this gave was only temporary.

By 1869 there were over 2,000 pauper lunatics in Middlesex still requiring 'asylum'. Colney Hatch was already overcrowded and in the latter half of the 19th century there were a series of transfers to hospitals and asylums in other parts of the country. In 1893, Claybury in Essex opened and took 350 patients, however, the overcrowding problem was still not resolved.

In 1903, a temporary building for 320 women burnt down with the loss of 51 lives making it the worst disaster in English asylum history. Consequently, and despite the conviction that enlargement was not in the interests of established patients and staff, work began on the asylum's third major enlargement in the form of seven Italian-style villas in 1908.

During and after the First World War, there was an increased demand for beds at Colney Hatch, first for the war-wounded and then for those suffering from mental disorders arising from their wartime experience.

It was envisaged that the overcrowding situation would be relieved by the Mental Treatment Act (1930) in that the two new categories of patient (voluntary and temporary) would remove the stigma and formalities of certification and bring in early and milder cases who would spend a shorter time in hospital. The LCC duly established psychiatric outpatient departments in Islington, Highgate and Archway which later combined at the Whittington Hospital to examine people for voluntary admission. However, few early and mild cases were actually admitted to Colney Hatch. In 1937, there were 2,654 patients (an all time high) of whom only 25 were voluntary.

During the Second World War, Friern had to provide six wards for war casualties which meant there was a congestion of patients on other wards and severe overcrowding. As the mental hospital nearest the centre of London, Friern suffered more bomb damage than any other - 36 patients and four nurses were killed, 300 female beds were lost, and some patients had to be evacuated to other mental hospitals. However, in 1947, there were still c. 2,600 patients residing in Friern.

By 1953, the anticipated effect of the 1930 Act began to be observed - patients in residence had decreased to 2,276 with 274 in the voluntary category. However, there were 959 admissions, which was three times the yearly admission rate before the war, although 489 were voluntary.

On 21st January 1965, when Mrs Barbara Robb first crossed Friern's elegant main portal to visit Miss Amy Gibbs, a retired seamstress in her mid-70s, on Ward E3 (a

long-stay ward for confused elderly people), the hospital population was just over 2,000. Wards were extremely crowded and three had as many as 70 patients on them. (Coltrane, 1990, p43)<sup>2</sup>

By 1973, the number of patients had dropped to approximately 1,100, but now Friern had its own Outpatient Department and Day Hospital which catered for 2,000 referrals per year.

### Site and Building

On 8th May 1849, Prince Albert laid the foundation stone and dedicated the Asylum to 'non-restraint' a method of treatment initiated by Dr John Connolly, the Superintendent of Hanwell. The plot of land on which Colney Hatch was built originally comprised 118 acres and cost nearly £18,000. It was later increased to 138, then 165 acres. The site was chosen because it was adjacent to Colney Hatch Station (now New Southgate) on the Great Northern Railway line running from Kings Cross to Peterborough which was under construction, at a time when horse transport was the only alternative.

The neighbouring area was uninhabited except for a cottage opposite the Main Gates and a small village some distance away. Everyone entering the asylum had to pass the porter at the Entrance Lodge.

On the extensive site, Colney Hatch had its own farm, orchard, garden, brewery, bakery, gasworks, waterworks, sewage system, laundry, schoolrooms, church, synagogue, and burial ground. After the First World War the farm

contracted, after the Second World War it was abandoned and the hospital site was reduced to 85 acres when land was sold back to MCC to make the North Circular Road.

Colney Hatch was the longest asylum ever built. The whole building comprised six miles of corridors and the long gloomy one running the length of the building which divided the asylum into two wings (originally Male and Female) plus the frontage was a third of a mile in length. The final cost of Colney Hatch was £300,000 making it the most expensive asylum ever built. However, within five years, the asylum required large sums of money to bring the building up to standard but this was not forthcoming.

The original building was devoid of interior decorations - it had bare brick walls and black asphalt floors which were particularly cold at night. The wards were tunnel-like, ill-heated, poorly lit and ventilated, and the Gothic windows were curtainless until 1957. The sight of patients crouching in corners was common due to a lack of furniture.

Over the years, staff tried to counteract the dehumanizing effects of the stark environment by making Friern a 'homely' place to live in, and wards were brightened-up with pictures and plants. In the 1960s, the walls around Friern Hospital began to come down a few feet at a time, the Main Gates and 'the sentry' were removed, and the long corridor was decorated with paintings produced in art therapy. However, whilst the desire to upgrade the hospital environment gained momentum, little was done to

check the physical deterioration of the building as shown by the dripping pipes and broken windows on the back wards.

### Staff

Despite pleas for an adequate number of doctors to make the asylum like other hospitals, Colney Hatch opened with only two medical staff - the Medical Superintendents for male and female patients, and they lived in the asylum. In 1890 the two Superintendent posts were combined and the new Medical Superintendent became the manager of the hospital and farm - a powerful office which survived until 1960 when it was replaced by that of Hospital Manager.

In 1859, four additional assistant doctors were employed to look after a patient population of 2,000. Since patients were not allowed to be moved to other hospitals for treatment of any kind, asylum doctors had to cater for all their medical needs, for example, perform operations, deliver babies, and carry out autopsies, as well as look after 300 staff. After the First World War, there were nine doctors employed in the asylum.

The asylum doctors had no control over admission and they did not see people before they came in. Under the 1845 Lunacy Act, the procedure for admission to Colney Hatch Asylum was as follows: the Parish doctor declared a person insane and a Magistrate placed the person on a compulsory reception order; the person was then admitted (except in an emergency) by prior arrangement between the parish officers and the asylum clerk whose office was in Upper Street, Islington.

It was initially difficult to recruit asylum staff, especially on the female side probably because female staff were paid 40% less than their male counterparts whose wages were already less than that of servants. Also, nursing attendants had to endure the same harsh living conditions as patients and their duties were arduous because many patients were very disabled. Staff were blamed and might even be dismissed if patients killed themselves, and nurses had to work a 90 hour week until the Second World War.

The non-restraint method to which Colney Hatch had been dedicated required 24 hour attendance, so nurses slept in side rooms until the first Nurses Home (Beech House) was converted from the female convalescent home in 1914. However, the majority of male nurses continued to sleep on side-wards until 1959. In 1968 the segregation of the sexes finally ended at Friern and mixed nursing began.

After the Second World War, existing hospital staff were gradually joined by a wide range of specialists - social workers, art, music, occupational and industrial therapists, psychologists, physiotherapists, a remedial gymnast, chiropodist, dental surgeon and radiographer. The Central Library and Training School also opened in the immediate post-war period.

In 1948, four consultants were appointed who each had responsibility for a quarter of the patients and the employment of part-time consultants was introduced. In theory, they now manned the Whittington Clinic on an equal footing with their general hospital colleagues but in



practice they were not required to make a diagnosis but to vet the suicidal and remove the unwanted.

The Academic Department of Psychiatry of the Royal Free Hospital was founded at Friern in 1971 and the Medical Research Council funded a research unit. Friern also had a Regional specialist in forensic psychiatry, three psycho-geriatricians, and two psychotherapists, and was visited by specialists from other disciplines. (UCL, 1987, p5)<sup>1</sup>

### Patients

As its name suggests, Colney Hatch Pauper Lunatic Asylum was originally for people who were the unfortunate victims of both poverty and mental disorder. The early patients wore a uniform of grey cloth and hair-cutting was of the prison-type. As a result of the Mental Treatment Act (1930) patients were able to wear their own clothes, although very poor long-stay patients still had to rely on the State for clothing.

Nobody was refused admission to Colney Hatch because of the hopelessness of their condition. It provided asylum for adults and children with many different illnesses and conditions - mania, melancholia, dementia, mental handicap, epilepsy, diabetes, syphilis, deafness, dumbness, blindness, and brain damage. However, the majority were suffering from some form of brain disease and were considered to be chronic or terminal.

All major denominations were catered for at Colney Hatch, and Jewish patients were sent there from all over the country because it had special arrangements for the

preparation of food and religious ministrations. Friern continued to cater for patients of all religions and to be the chief institution for the mentally ill of the Jewish faith.

Due to the overcrowded conditions, patients were particularly susceptible to infectious diseases such as tuberculosis, typhoid, and dysentery. Pulmonary tuberculosis was, for 100 years, the 'twin sister of insanity' - after brain disease, it was the most common cause of sickness in the asylum. causing about 15% of the deaths. When the laboratory was completed in 1923, it was used to help control cross-infection rather than an aid to research into the causes of mental disorder.

#### Treatment of Patients

When people were admitted to Colney Hatch, they were placed on wards with others who had similar disabilities. This was a way of governing the insane which was particularly important at Colney Hatch due to the huge size of the population.

Since Colney Hatch could only take certified patients and patients could not be certified until their illness was obvious, doctors did not deal with early diagnosis and treatment of mild or acute cases. Colney Hatch was, therefore, an asylum first and hospital second - it could only 'cure' a minority and 'contain' the rest. Early neglect of patients was inevitable because of the high ratio of patients and staff to doctors, and the relentless pressure on beds, particularly for chronic and incurable

cases, forced the asylum even further away from the idea of a hospital.

Although the asylum had been dedicated to non-restraint, very disturbed patients were kept in 'strong clothes' or padded rooms, or slept on water-beds and canvas stretchers, and some had to be forcibly fed. Early patients were the recipients of a variety of remedies: Turkish baths, alcohol, opium, and tobacco. Beer was a cheap remedy because the asylum had its own brewery until 1895 but the expenditure on snuff and tobacco was considerable and often greater than that spent on medicines.

By law, Colney Hatch had to have a Chaplain because spiritual consolation was considered to be an important aspect of 'moral treatment'. The first Chaplain, Reverend Henry Hawkins, founded a 'Guild of Friends of the Insane at Colney Hatch' and published two papers in the Journal of Mental Science stressing the urgent necessity for some intermediate form of care for discharged patients because the prospect of permanent recovery greatly depended on the patient's circumstances on first resuming 'ordinary' life. In 1879, he formed an association for the 'Aftercare of Poor and Friendless Convalescents on Leaving Asylums for the Insane' and raised funds to provide hostels in the community for ex-patients. From 1915, this was known as the Mental After Care Association.

The death rate in Colney Hatch was higher than the recovery rate and recoveries, as a proportion of admissions, were recorded as between 30% and 60% annually although some patients recovered and were discharged after many years.

According to the LCC's records (1895-1927), of the 4,843 patients discharged 'recovered', 31% relapsed and had to be readmitted, half within 12 months of discharge.

Just as the asylum doctors had no control over admissions, they could only advise on discharge and the criteria for recovery was strict. However, since discharge for some patients meant a return to the Workhouse, they were unwilling to leave the asylum and threatened to kill themselves if they were discharged and attempted suicide in order to return.

The main complaints investigated by the Committee of Visitors were improper confinement and bad behaviour on the part of staff. The Committee of the Board of Control expressed the same concerns about the conditions of patients on the long-stay wards as their predecessors, the Commissioners in Lunacy - disease, overcrowding, poor diet, lack of occupational and recreational facilities, poor maintenance and decoration of wards.

Due to the overcrowding and economic pressures in the post Second World war period, psychiatrists were forced to apply the new physical treatments (Insulin Coma Therapy and ECT in 1946, and Prefrontal Leubotomy in 1947) to make patients socially acceptable again, even if only temporarily, for discharge. Psychotropic drugs began to be prescribed at Friern in the late 1950s and seemed to alleviate some of the stress and suffering caused by mental illness. They made it possible for patients to receive rehabilitative therapies, helped some to leave hospital sooner, and to prevent relapse.

Psychotropic drugs took the credit for creating a calmer atmosphere in Friern which was ideal for an 'open-door' policy, however, although the average length of stay of acute patients dropped, admission especially readmission rose, so it was really a 'revolving-door'. Further, the considerable side-effects of the psychotropic drugs which were irreversible such as problems of speech and posture, stiffness, tremor, involuntary spasms of muscles were not immediately apparent although they were very obvious in the long-stay patients who became part of the closure programme.

In line with the 1930 Act, Halliwick House, the 145 bedded block for acute admissions was built in 1958. However, it developed into a neuroses unit with a strongly psychotherapeutic emphasis for less sick and socially superior patients which tended to divert resources away from long-stay patients.

Visiting Amy Gibbs in Friern Hospital in 1968 was the initiation of Mrs Barbara Robb, the Labour Peer Lord David Strabolgi, and the poverty campaigner Mrs Audrey Harvey into the twilight world of the back wards of British Mental Hospitals. Within six months, they founded the elite pressure group Aid for the Elderly in Government Institutions (AEGIS) and within a year Mrs Robb spearheaded a national media campaign on conditions in psychiatric hospitals and was engaged in a protracted wrangle with the Ministry of Health to change them. (Coltrane, 1990, p2-3)<sup>2</sup>

At Friern, Mrs Robb and colleagues found old ladies with cropped hair, dressed in ill-fitting State-issue pinafores, deprived of teeth, spectacles, and hearing aids,

sitting listlessly in the day rooms (The Guardian, 1989)<sup>3</sup>. This practice of cropping hair on admission, removing spectacles, dentures, and hearing aids was justified by staff as a precaution against injury, but had its roots in institutional practices (Coltrane, 1990, p45)<sup>2</sup>. Friern was the subject of four contributions in *Sans Everything: A Case to Answer* (1967), including that of Barbara Robb herself entitled 'The Diary of a Nobody'. In *Sans Everything*, it was argued that elderly patients in Friern were not mentally ill, but since they were living alongside those who were, and receiving ECT, this was detrimental to their health (Robb, 1967, p112-113)<sup>4</sup>.

Seven days before the publication of the *Sans Everything White Paper*, a patient was found dead in the hospital grounds after six weeks of absence from his ward (Hornsey Journal, 23.8.68). Official investigations into the allegations of neglect at Friern Hospital made by Mrs Robb and her colleagues revealed that Friern was overburdened with patients who ought not to be there (Ministry of Health, 1968a, para 105)<sup>5</sup>, much of patient's clothing was of poor quality and appearance (ibid, para 113)<sup>5</sup>, wards were seriously overcrowded and Friern was functioning as a 'dump for geriatrics' (Ministry of Health, 1968b, para 117)<sup>6</sup>.

Investigations also found an acute shortage of nurses, especially trained nurses, that several wards were virtually unstaffed apart from an hourly visit by a charge nurse or sister, and that a serious shortage of domestic staff resulted in trained nurses doing domestic work on top of all their other duties. (ibid, para 121)<sup>5</sup> Further, the

administrative side of the hospital required a drastic overhaul, there was no satisfactory social work department, and OT provision was inadequate (ibid, para 127 & 128)<sup>5</sup>.

The 1959 Act had emphasised the reorientation of mental health services away from institutional care to community care and during the 60's, 70's and early 80's, Friern social workers and consultants managed to move a small but steady number of patients out of the hospital. Nursing staff, however, had very little involvement in this work and their role continued to be a custodial one. The main problem in the rehabilitation of long-stay patients was finding places in the boroughs served by Friern for them to move to. Consequently, they were often sent to hotels, hostels, and homes in seaside resorts such as Margate which were prepared to take people for the amount the Department of Health and Social Security (DHSS) were willing to pay. Some rejoiced in their freedom, but others became ill and had to return to Friern Hospital. (Interview, 1990)<sup>7</sup>

#### Work and Social Activities

Work and social activities were enduring features of the life of patients in Friern apart from during the First and Second World Wars when staff were required for the war effort, and staff shortages led to a curtailment of services to patients - there were few opportunities for employment and social and recreational life came to a standstill.

In the early years, Colney Hatch Asylum was a self-supporting rural community and all patients who were capable were employed in the running of the asylum - on the farm, in

the bakery, brewery and laundry. Brushmaking was the earliest asylum industry followed by shoemaking and printing. Beer, tobacco, tea and cakes were used as an incentive to work.

Although the farm contracted after the First World War and was abandoned after the Second, and the lack of demand for brushes resulted in this workshop closing down, Friern patients continued to be encouraged to work because of the perceived value of useful employment - it gave them self-respect and a measure of independence through their meagre earnings, thus counteracting the institutional syndrome. Some patients worked outside in family businesses or for employers on a part-time basis, for example, as cleaners. Others worked within the hospital in the stores, laundry, post room, and workshops. Although the workshops could only offer dull and routine work, such as packing boxes with confetti, they were well attended.

Since physical exercise was thought to be beneficial, early patients who could not work were sent into the Airing Courts daily to exercise. When the weather was bad, they went to the Exercising Hall (which became the Main Hall). Supervised patients were allowed to walk in the neighbourhood in 'ordinary' clothes so they would not be so easily identified as patients from the asylum which might offend the public. However, exercise beyond the grounds became more difficult as the number of houses and inhabitants in the area increased.

Visitors were initially encouraged but by 1854 they had become so numerous that the Committee of Visitors was



compelled to limit the number of visitors per patient on visiting days to two, excluding children in arms, a regulation which remained in force until 1964.

Before the First World War, dances and other entertainments were also held in the Main Hall, and relatives and others were invited to cricket and football matches, fetes and concerts at Colney Hatch. These social events also seemed to have a beneficial effect on patients and did much to improve the public image of the asylum - from a place where patients were unwillingly detained to a kindly shelter in pleasant surroundings. There were also excursions to the country, places of interest, and Christmas shopping trips to Wood Green and Finchley. However, the Committee of Visitors had to reconcile their duty to the patients with the security of the public so even the most tranquil patients had to be accompanied beyond the asylum grounds.

After the First World War, overcrowding and the financial stringencies of recession increased the restrictions on patients' freedom - 90% lived on locked wards and were confined to ward gardens for fresh air. As a result of the 'voluntary' category introduced by the 1930 Act, more patients were allowed out although there was a strict system of Parole (Corridor, Ground, Town, and Special Town) which was maintained until the 1960s. In 1937, the Main Gates which had been closed since 1890 opened although only seven men were allowed out unattended.

After the Second World War, social and recreational life was revitalised with dances, sporting events and trips

to the cinema. However, by 1953, 75% of patients still lived on locked wards.

The television became an established form of hospital entertainment and it was not uncommon to see patients sitting in front of their ward television for hours at a time without changing a channel, or to see the flickering images 'performing' to nobody. However, patients also went on swimming outings, trips to the seaside, and had weekend discos. They were enabled to go out of the hospital by free travel permits and encouraged to attend Day Centres in the boroughs which Friern served.

## PART 2 - THE CLOSURE OF FRIERN HOSPITAL

### The Recommendation to Close Two of NETRHA's Hospitals

In May 1980, the Regional Policy Group on Mental Illness concluded that the mental illness service was fragmented, undermanned, and lacked provision for whole categories of patients. It was also grossly underfunded, which could cause the quality of the service to decline, and a major portion of the premises was ill-suited to the needs of modern psychiatry. It, therefore, recommended that two of NETRHA's six large hospitals (Severalls, Runwell, Warley, Friern, Goodmayes, Claybury) be closed. (NETRHA, 1982, p1)<sup>8</sup>

### The Criteria for Identifying which Hospitals should Close

NETRHA chose two criteria for identifying the hospitals which should close - Service Provision and Finance. The Service Provision Indicators were: Yates' Indices (size of hospital, percentage of patients over 65, number of patients per consultant/nurse/therapist, and length of stay); geographical location; coherence of catchment areas; extent of local provision; and, specialist or other facilities on site. The Financial Indicators were: total revenue expenditure; unit cost; trend of unit cost; site value; backlog maintenance costs; and, major upgradings planned. (ibid, p23 para 123, p24 para 104)<sup>8</sup>

With regard to the Service Provision Indicators, Friern was below average on the Yates' Indices because of its large size and slow rundown (ibid, p24, para 105)<sup>8</sup>. It was situated outside the catchment areas it served but was relatively accessible. It served four districts and had

relatively fragmented catchment areas. There were some elements of local service in the catchment areas of Friern but they would need c. 300 extra beds. Friern had a range of specialist services which, if the hospital closed, it would be uneconomic to retain in isolation. (ibid, p25)<sup>8</sup> On the Financial Indicators, Friern was costing £2m per year, and a Friern patient was costing £30 per day. The Friern site was estimated to have the greatest value of the six hospitals. Friern required £4m for backlog maintenance and £10m for major upgrading, and both these sums were greater than that required by the other hospitals. (ibid, p26)<sup>8</sup>

The Service Provision Indicators identified Claybury and Friern for closure, and the Financial Indicators tended to select Friern and Severalls. The Regional Team of Officers considered the extent of local provision to be the most significant. (ibid, p26, paras 121 & 123)<sup>8</sup> Since NETRHA recognized that staff became anxious when closures were rumoured and would prefer an early and firm decision so they could take a constructive part in planning the new service, it intended to make a decision as soon as possible after the end of the consultation programme and, within 12 months thereafter, to have an agreed programme for action (ibid, p26, para 29)<sup>8</sup>.

In November 1982, NETRHA noted that the response to the consultation programme was unanimous with regard to the move towards district and community-based services but that there were reservations on whether the level of funding and provision in the community would be adequate to meet future needs and care for existing long-stay patients in the large

institutions. On the service provision criteria in particular, Friern and Claybury seemed the most suitable for closure because their backlog and future maintenance requirements were also significant. NETRHA, therefore, commissioned two studies to report by 30th June 1983 whether it was feasible to provide comprehensive district services in the catchment areas of Claybury and Friern Hospitals in the foreseeable future. (NETRHA, 1993, p1)<sup>9</sup>

A Steering Committee for each hospital was set up. It comprised Regional and District Officers, Medical and Nursing Advisers, and Social Services staff, and met monthly. The Steering Committee had to: undertake a joint assessment of individual patients; determine the NHS facilities and services required in each district, the broad revenue and capital costs of providing them, and a realistic pattern for their implementation; determine any multi-district services required on the hospital site; determine the broad personnel implications; and, consider joint planning for the complimentary local authority services. (ibid, paras 3, 4, and 5)<sup>9</sup>

#### The Friern Closure Feasibility Study

Several important issues arose from the Friern feasibility study. The fabric of Friern was totally unsuitable for the practice of modern psychiatry. It encouraged dependency among long-stay patients especially the elderly and their relative remoteness from their catchment population cut them off from family and friends. However, professional staff thought that some forms of provision for certain groups of

patients should continue to be located in the spacious and isolated hospital site.

There was enthusiasm in the districts for the move and the move was desirable from a service planning and patient care standpoint in that it would provide a more domestic environment for long-stay patients - small units could be as cost effective as large and there would be qualitative benefits to patients. However, uncertainty about the future of the hospital had lowered staff morale and had an adverse effect on patient care.

Local authorities could only play a part if health service money was transferred through Care in the Community type schemes or joint finance. Expenditure cuts in 1983/84 could be recurring and, in financial terms, the proposals put forward and costed by the DHA's were not achievable in the existing economic climate.

If the bulk of the backlog maintenance at Friern could be avoided, then this and the money to upgrade wards would be available to direct to new provision. The value of the Friern site was potentially very high but dependent on the land retained for health purposes and the listed main frontage. (ibid, paras 38.1-6, 39, 40.3-4, 57, 62 & 64)<sup>9</sup>

#### Criticisms of the Feasibility Studies

Researchers from King Edward's Hospital Fund for London, who had spent 30 days over a period of seven months observing the Regional and District groups involved in the feasibility studies and discussing progress and problems with key

participants, identified a number of problems and limitations (Towell & McAusland, 1983)<sup>10</sup>.

The feasibility study concept was ambiguous and problematic. Terms were interpreted differently by Districts so it was difficult for NETRHA to assimilate their responses. Also, feasibility studies were based on financial assumptions and there were information gaps, for example, on patient and community needs, because of the tight timetable and/or inavailability.

Due to heavy staff workloads and having a timetable for the production of reports, there was some 'steam-rollering' to ensure consensus, and innovative proposals were excluded. There were complex organisational mechanisms at work within and between the agencies involved and organisational relationships could be coloured by experiences in other areas of work and attitudes shaped in Friern's long history. Steering Groups tended to be 'Region v. the rest' and were, therefore, unproductive with regard to mutual support, sharing ideas and disagreements.

Apart from patients whose interests had not been taken into account, staff would be most affected by the Hospital closure. However, apart from Consultant Psychiatrists, the importance of staff was not reflected in the consultation process as seen, for example, in lack of their attendance at Steering Groups. Also, personnel policies were underdeveloped.

NETRHA had developed a too 'laissez-faire' attitude towards forms of provision, for example, on philosophies, operational policies, and extent of local authority

contributions. Also, although some commitment, interest, and motivation was mobilised locally during the feasibility studies, some people whose contribution would be vital, for example, DHA members and clinicians, continued to have reservations about the decision because of doubts about the quality and comprehensiveness of local services that could be provided with estimates given by the Regional Team of Officers. (ibid, para 3)<sup>10</sup>

Further, senior hospital staff who had argued most forcefully against NETRHA's original consultative proposals may be unenthusiastic leaders for the major changes required, and other hospital staff who felt little consulted and uncertain about their future may initially see the changes as a loss of opportunity (ibid, para 11)<sup>10</sup>.

#### The Outcome of the Feasibility Studies

In spite of the criticisms and reservations expressed, NETRHA finally concluded that: Friern user Districts thought that the provision of local community-based services within the catchment areas of the hospital was feasible; services would be needed on at least part of the Friern site in the long-term, including a sub-Regional Medium Secure Unit; and, the amount of maintenance needed to preserve the present Friern fabric and the mounting cost of providing services to a steadily reducing patient population had made some changes inevitable. (ibid, para 34.1 & 34.3)<sup>10</sup>

It was the opinion of NETRHA that the move to comprehensive district based services could be achieved within 10 years. Although capital funds would be



substantial, they could be found from within the capital programme. The main area of uncertainty was the revenue funding required and the levels of staffing necessary.

(*ibid*, paras 36 & 37)<sup>10</sup> The Regional Team recommended that plans should proceed as rapidly as possible, to disperse the services in Friern with a view to disposal of the site no later than 1993, with the provision that Halliwick House and its immediate area were retained for patient use and other facilities up to 200 beds, including a supra-District Medium Secure Unit of 20 beds (*ibid*, para 166)<sup>10</sup>.

The Region felt that the shorter the period of time taken to close the hospital, the less anxiety and frustration for staff and patients. Since hospital staff would be essential to completion of the plan, it was necessary to allay their anxieties. NETRHA, therefore, expected the DHAs to bear in mind the advisability of: a discussion with each individual to minimise uncertainty; establishing opportunities for redeployment retraining; consulting staff organisations; and, giving first consideration for redeployment to staff currently employed within the Region. (*ibid*, para 69)<sup>10</sup>

In July 1983, the Regional Medical Officer of NETRHA appeared on television to announce the closure of Claybury and much of Friern (the Region's two largest hospitals) over a 10 year period, without decanting patients into other psychiatric hospitals. Provision in the community for long-stay patients, as a result of the decision to close Friern, became the responsibility of one of the four health

districts the hospital served, although about one sixth had originated in other districts (UCL, 1987, p1)<sup>1</sup>

NETRHA operated a 'hands-off' policy in that Districts were expected to plan, negotiate, and manage their own programme of institutional rundown and community reprovision, unless they could not agree on a way forward. Thus, there was no single 'service model' and due to the variety of interpretations of community care, a wide range of schemes were developed. (NETRHA, 1989, p2)<sup>11</sup> However, NETRHA perceived an 'ideal' community care unit to be off a hospital site, small (under 25 places, with a domestic environment - an ordinary house in an ordinary street being best of all). Further, the transition from institutional care to community care should be a single step, people should not be moved from one hospital to another. (NETRHA, 1988, Annex A, para 2)<sup>12</sup> Another of the few stipulations for reprovision laid down by NETRHA was that patients should be discharged with their friends (Dunn et al, 1999)<sup>13</sup>.

#### District Funding of the Friern Closure Programme

Districts received a Dowry for Friern patients. The dowry was calculated by dividing the total cost of running the hospital by the number of patients. The money was transferred from the hospital budget to the health district receiving the leaver when this resulted in the permanent closure of a bed. In 1988, this transfer payment was between £16,000 and £17,000. If the health district did not provide the whole service, dowry money could be passed to

the Local Authority SSD's or voluntary organisations. (Knapp et al, 1990)<sup>14</sup>

In recognition that community care may cost more than institutional care, NETRHA also made a Strategic Reserve available to districts to provide additional revenue to support community reprovision schemes. Once approved, they would become permanent sources of revenue. NETRHA also provided Bridging Finance to enable Friern to continue to function while its budget was reduced by the departure of individuals and their dowries. Districts had to bid for capital funds to develop community services. (NETRHA, 1989, p2)<sup>11</sup>

From April 1991, however, the funding of the Friern closure programme changed. Instead of being able to 'cash in' revenue for each bed closure, Districts were 'invoiced' each month by the hospital for the services contracted for patients. This was not cheaper because the hospital still had to provide essential services for the ever-diminishing number of patients. Thus, the unit cost of patient care increased as the hospital population decreased.

#### The Reaction of Staff to Friern Closure

There were approximately 650 nurses and 40 doctors at Friern when the decision to close was announced on television. The initial reaction of staff was one of shock and disbelief because it was the first time they had heard about the Friern closure, and the Government had been talking about hospital closure since the 1960's, but nothing had happened.

Nursing staff felt threatened by Friern closure because they were concerned about their future, especially those who had worked in the hospital for many years. They were worried that they may not be considered suitable for employment in the community or given the opportunity to retrain. The whole fabric of their lives had been built around working in the hospital environment - their family life had been organised around the shift system and their mortgages were based on shift payments. This was particularly true for the large number of married couples working at Friern.

Some nursing staff believed that closing down large mental hospitals was a good idea but, apart from the uncertainty about their own future, they were concerned that patients might suffer if Friern was closed too quickly in that there would be inadequate facilities in the community and they would not be given enough time to adjust to the move.

Some nursing staff were actively involved in opposing the closure on an individual basis or via their Trade Union - COHSE. Some Friern doctors were also anti-closure. The organisation Care of the Neglected: Combining Education, Rehabilitation and Nursing (CONCERN) was set up by two Consultant Psychiatrists at Friern Hospital (Haringey's Dr M Weller and Islington's Dr D Hollander) as a result of their 'concern' that the plans for closure of large mental hospitals and patient care in the community were being undertaken without adequate resources and may result in homelessness. These particular Consultants were unrelenting

in campaigning for the retention of Friern as a mental health facility. (Interviews 1989-90)<sup>15</sup>

### The Effect of the Closure on Nursing Staff

Initially, staff were not kept well-informed about the Friern closure plans. When wrong information was 'picked-up', the resultant rumours that spread took a long time to diffuse. This may explain why many nursing staff still did not believe that the hospital was going to close even when Senior Nursing Officers became involved in closure plans and they received letters from Hampstead Health Authority asking them to indicate their 1st, 2nd, and 3rd choice of district with regard to future employment in the community.

The majority felt that they should have first option on employment in the community and that they should move with the patients that had been in their care. Initially, however, they were only given verbal assurances of employment in the community and it was a long time before actual jobs were discussed. This lowered staff morale and standards.

After the closure announcement, there was an increase in nursing staff turnover and it became more difficult to recruit staff. The newly-qualified staff tended to leave the hospital first, either for alternative hospital-based employment or for new projects in the community, while the older staff stayed on with the most vulnerable of the long-stay patients. It became increasingly difficult to recruit new staff as the closure programme progressed which

necessitated the employment of greater numbers of agency staff.

Some nursing staff attended English National Board (ENB) Courses to train for positions in the community (ENB953 for acute mentally ill, ENB941 for elderly, ENB945 for rehabilitation), and some nursing assistants took City & Guilds examinations to become care assistants in the community. For others, however, the opportunity for retraining never materialised with the result that they were unable to understand the concept of community care and were not considered suitable for employment in the community. Regrading was a nightmare for all districts - Grade F was the highest in the hospital but some senior community posts required Grade G.

There was much 'swopping' and 'poaching' of nursing staff between districts. The net result of the continual movement of staff between districts was that they became increasingly disestablished and susceptible to yet further alternative offers. Consequently, their morale and standards remained low.

Reliance on the shift system, especially by married couples, was thought to explain why some staff opted for projects which would only become operational near the end of the closure programme - they were postponing the changes that would occur in their living standards and arrangements for as long as possible while looking for other hospital-based jobs with comparable working conditions.

The custodial aspect of the nurse-patient relationship changed after the closure announcement when rehabilitation

became a focal point of the work of nursing staff. The closure decision also brought new 'professionals' into the hospital - workers from voluntary and statutory organisations seeking to identify patients for projects they were setting-up in the community and other workers employed by the statutory organisations to facilitate the move from the hospital to the community. Some nursing staff welcomed these 'outsiders' while others felt threatened by the invasion into their domain by workers who had no knowledge of the patients and who appeared to be 'taking-over' their work. Some nursing staff were accused of thwarting the attempts by these workers to get to know patients and encourage them to move to their projects in the community.

The new staff brought with them new ideas and philosophies on the care of the mentally ill and for a long time they could neither agree between themselves nor with the staff already in residence, thus creating a potentially explosive situation. It was only as the responsibilities of the new staff became more clearly defined, as nursing staff became more informed about and involved in the closure programme and more secure about their own future, that the majority began to adopt the official line on closure and these difficulties began to be resolved.

As their closure programmes progressed, districts operated with increasingly intricate administrative structures, with some staff dividing their time equally between hospital and community and most Friern Consultants taking-up a second role - Community Psychiatrist. Hospital and community-based staff of both statutory and voluntary

organisations were expected to attend a plethora of meetings both in the hospital and in the community, at district and regional level, to effect the closure of Friern. Nearer the end of the closure programme, workers employed to facilitate the move to the community began to decrease in number, become redundant altogether, or hand over their responsibilities to their counterparts in the community. (Interviews 1989-90)<sup>16</sup>

#### Patients in the Closure Programme

Reference has already been made to Friern patients in Chapter 1, in particular the characteristics of the Friern long-stay patients (non-demented) which were compiled from the TAPS Baseline Survey (See *Appendix 1.7*). Additional findings of the TAPS research with regard to long-stay patients were discussed in Chapter 3 (p62-66).

The majority of long-stay patients (non-demented) were suffering from schizophrenia. However, they were not necessarily the worst cases, but people who were lacking family or support networks which could help them to remain in the community. Some were 'burnt-out', some could control their symptoms with the help of drugs, and some were suffering from the debilitating effects of institutionalisation and/or the side effects of drug therapy.

(Interview 1989)<sup>17</sup>

There were some long-stay patients who had been in Friern for 60+ years (Tomlinson et al, 1996)<sup>18</sup>. There were many social reasons why these people may have welcomed admission to hospital but there were three dominant reasons



for them to be admitted - 'terror', 'trauma' and 'troublemaking'. Some had seemed happy to remain in hospital because of its 'refuge' function from an early stage in their institutionalisation and despite successive rehabilitation drives in the 60s, 70s, and 80s. This group had seen many changes in the hospital over the decades and case-note records showed that they consistently failed to give a coherent 'account of themselves' when examined by hospital staff, albeit that they were also allowed by staff to remain 'incoherent' for extended periods. The perception of long-stay patients as being vulnerable to abuse or public censure appeared to have been of relatively recent origin in terms of case-note records, thus attributing the cause of many 'long-stays' to institutionalisation.

After the closure announcement, long-stay patients became the focus of 'professional' attention - patient assessments, trips to the community, cooking classes, and self-medication programmes. There was also an increasing stream of visitors, such as workers employed by the managers of projects in the community and researchers, passing through the Reception, and from whom patients could 'cadge' cigarettes.

Patients who had more than £25 were expected to contribute towards the cost of their clothing and other personal items for discharge. However, an amount of up to £250 could be obtained from the Hospital's Endowment Fund, when a patient had insufficient funds to be 'properly dressed' for the move to the community, with a recommend-

ation that clothes be bought from the Hospital Boutique.  
(Interview 1989)<sup>17</sup>

### Hospital Admissions

In the year in which the decision to close Friern Hospital was announced (1983), there were approximately 1,200 admissions. This was largely due to the growing number of older people in the population sometimes suffering from both physical illness and senile dementia. However, they did not greatly increase the long-stay population in the hospital because their turnover was high due to death. In 1987, there were c. 1,300 admissions and by 1989, the figure had risen to c. 1,500. (Interview 1989)<sup>17</sup>

The increase in the total yearly hospital admissions had not been foreseen and districts began to experience problems in catering for admissions at Friern because beds were disappearing as the closure programme progressed and there was a limited availability of bed spaces in the psychiatric wings of their District General Hospitals (DGH). By 1992, there was a real crisis due to the vastly inadequate number of beds to meet the growing demand for admission. Consequently, there were times when most people could only be admitted to Friern or psychiatric wings of DGH's under a Section, and health authorities were forced to purchase bed spaces for other admissions in private hospitals. Whereas, once these acute admissions could have stayed in Friern for a few weeks, now they could only stay in private hospitals for a few days before being discharged,

unless their relatives could afford for them to stay longer.  
(Interview 1992)<sup>19</sup>

### The Rundown of Hospital Services

As the closure programme unfolded, the peripheral hospital buildings were vacated for demolition, and the main building was gradually taken out of use, working from the back to the listed frontage. As a result of the retrenchment of the main building, 28.5 acres were sold in three and a half to nine acre parcels (NETRHA, 1990, p5)<sup>20</sup>. Running repairs were kept to a minimum until 1990 when £0.7m was required for immediate repairs and temporary boiler capacity in the hospital frontage so that the boiler at the back could be taken out to enable land sales in that area (ibid, p4 & 5)<sup>20</sup>.

Ward closures had an adverse effect on both patients and staff. There were conflicts between the managing district of Friern (Hampstead) and the other districts with regard to ward closures because the former had to bow to financial considerations rather than basing closures on a natural retrenchment. (Interviews 1989-90)<sup>15</sup>

As ward closures were effected, there was a gradual closing-down of central services. When the Patients Affairs Department closed in March 1990, the affairs of patients became the responsibility of ward teams. Six months later, the Reception closed under a storm of protest, especially from those who were concerned about conditions in the hospital for those who had been left behind and those who

had been campaigning for the retention of the hospital.

(Interview 1990)<sup>7</sup>

By June 1989, 112 non-demented long-stay patients had left the hospital (Knapp et al, 1990)<sup>14</sup> Since it had been the sheer size of the Friern population which made social events and outings possible on a regular basis, as the closure programme progressed and the inpatient population decreased, these were not considered to be so necessary or financially viable. Patients certainly had more visitors and those that were preparing to move were increasingly encouraged to attend Centres and events in the community but, apart from monthly Jumble Sales, there was little in the way of social and recreational life for patients still living in the hospital. (Interview 1990)<sup>7</sup>

Although districts had made plans for work-related schemes in the community for patients who were part of the closure programme, the operational dates of these schemes were largely well behind housing projects. As a result, many patients who had left the hospital continued to return for employment purposes. Since some ex-patients preferred to return to the South Workshop at Friern even when there were alternatives in the community, this was one of the last hospital services to close.

### Early Closure Proposal

By mid 1988, NETRHA had a number of financial problems. There were great demands on the Regional Strategic Reserve (funds NETRHA had made available to districts to provide additional revenue to support community reprovision schemes)

because health districts had found that financial support from other organisations, especially local authorities, were less than anticipated. There were also great demands for Bridging Finance because of the significant double running costs which had been incurred with no pay back, in the form of land sales. (NETRHA, 1989, p4)<sup>11</sup>

In June 1990, NETRHA reached a crisis in its capital programme because: the increased cost of building works had exceeded the growth of the Regional Capital Allocation, and the receipts from land sales had been lower than expected or had not been realised. In order to balance its capital account, NETRHA advised districts that it was only projects in which capital works had commenced which would be allowed to continue, those that had not started would be put on hold while they looked at the feasibility of achieving the closure of Friern by September 1991. The early closure of Friern would: reduce immediate capital requirements by the temporary relocation of services into existing vacant accommodation; reduce the demand for double running costs; and, enable land sales to proceed more quickly. (NETRHA, 1990, p1)<sup>20</sup>

The Feasibility Study on early closure revealed that: Bloomsbury could complete existing plans by September 1991; Hampstead had no alternatives to existing plans and programmes and these could not be completed until 1992/93; Islington had a number of alternatives, the most publicised being the transfer of patients to the Royal Northern Hospital in Holloway; and, Haringey had three options - continue with its existing plan, using the Halliwick site to

be completed in March 1993 at the cost of £19m, have a mixture of its existing plan and some use of available wards at St Ann's Hospital at a cost of £10.7m or have extensive use of St Ann's at a cost of £7m. (ibid, 1990, p26)<sup>20</sup>

There was considerable general opposition to the proposal to close Friern early, on the grounds that it would cause distress to patients and their families because of relocation, and Friern staff had commitments to future employment (ibid, p26)<sup>20</sup>. There was also considerable local opposition in Islington to the use of the Royal Northern Hospital so that NETRHA could put the Friern site on the market. Moving patients from one institution to another was perceived to be 'treating them like potatoes' (Islington Gazette, 1990)<sup>21</sup>.

There was more focussed opposition to Haringey's use of St Ann's Hospital because: patients would be transferred to facilities no better than their current position and unsuitable according to NETRHA's 1983 directive; there would be an over-concentration of mental health facilities in one area of the district; it would create problems for staff expecting to be redeployed on the Halliwick site; and, there would be transport difficulties for patients and relatives travelling between the catchment area and St Ann's (NETRHA, 1990, p26)<sup>20</sup>.

Protestations about the negative effect that moving Friern patients 'en masse' from one institution to another to effect early closure would have on the most vulnerable patients in the hospital prompted NETRHA to reverse its decision to attempt to close the hospital 18 months early.

Instead, NETRHA made revisions and cuts in the planned capital programmes of each district. As a result, Haringey had to proceed with its third option - extensive use of St Ann's Hospital.

### The Hospital Fire

In the early hours of 17th November 1988, a fire broke out on Islington Rehabilitation Ward 15. It was believed to have been started by a cigarette end, and trapped three elderly male patients in the lounge at the back of the ward. So intense was the heat of the fire that the metal on the beds melted and buckled. The fire raged through the two storey wing housing Ward 15 and an administration department, and only stopped at a stone staircase. Two patients died as a result but the toll could have been much higher if staff and firemen had not managed to evacuate 150 patients who were very frightened and confused. (Hornsey Journal, 1988)<sup>22</sup>

### Health Authority Mergers

In 1988, a merger for administrative and medical school purposes between Haringey and Hampstead Health Authorities was proposed. However, as this would have absorbed a high proportion of resources and would have had serious implications for the catchment population of Haringey, the merger did not go ahead.

In July 1990, the Health Minister announced that the proposed merger between Bloomsbury and Islington Health Authorities was to go ahead. The announcement received a hostile reception from Islington Council, MPs and health

organisations. Islington Community Health Council was angry that responses to the consultation document had been ignored - out of 60 written responses, only three favoured the merger, and the vast majority had strongly objected. The main objection to this merger was that it would destroy Islington's coterminousity with the local council which had brought indisputable benefits, entail enormous costs, and be to the detriment of Islington's catchment population because Bloomsbury had a much larger overdraft than Islington. According to the NETRHA Chairman, a merger between Bloomsbury and Hampstead Health Authorities may have been more appropriate because it would have united the borough of Camden. However, this merger was not politically opportune. (Islington Gazette, 1990)<sup>23</sup>

The merger between Bloomsbury and Islington did not affect the planned projects for long-stay patients in the community - Bloomsbury and Islington patients still moved to projects in Bloomsbury and Islington, respectively. However, since Bloomsbury did not have such a strong link with the Friern administration as Islington, those involved with implementing Islington's planned programme had a more difficult relationship with the Friern management after the merger. (Interview 1992)<sup>24</sup>

## CONCLUSIONS

The following conclusions are based on the information presented in this Chapter. However, they also pose questions and make predictions about the care of ex-long-stay patients and other people suffering from mental illness



in the areas Friern served once the hospital finally closed. The findings presented with regard to Islington's closure programme, the ex-long-stay patients in the Pilot Study and in Islington, and other ex-Friern patients in Islington will go some way to answering these questions and testing these predictions.

1. Colney Hatch Asylum was built to reduce the cost of caring for pauper lunatics in workhouses, prisons, and houses of correction and detention, where they were neglected and maltreated, and it unknown which 'concern' carried the most weight - financial or humanitarian. However, the fact that funds necessary to check decay in the asylum within 5 years of opening were not forthcoming suggests that 'saving money' was the primary motivating factor.

According to NETRHA in 1982, Service Provision Indicators were more important than Financial Indicators with regard to the identification of hospitals for closure, although they did acknowledge that £14m would be saved if backlog maintenance and upgradings at Friern could be largely avoided, and that the Friern site was the most valuable. NETRHA also made some admirable statements about the benefits of closure to long-stay patients. When NETRHA experienced financial problems in 1991, however, concerns about the well-being of patients took second place - they were no longer so worried that some patients would have to move to another hospital temporarily or permanently if Friern could be closed earlier and they could capitalise on

the high value of the hospital site, which increased when Haringey was instructed to take-up its cheapest option. This makes it difficult to believe that NETRHA ever considered Service Provision Indicators to even be on a par with Financial Indicators.

If saving money was the motivating factor in selecting Friern for closure, this would explain why the timetable for the consultation process was so short - districts had inadequate time to explore all the implications of closure.

Thus, the prime motivating force in the opening and closing of Friern Hospital was to reduce costs, and the latter may have affected the closure programme, patients in the hospital during the closure, and the services and facilities available in the community to them and other people suffering from mental illness.

2. Friern patients consistently occupied a low rung on the social priority ladder. This can be seen in the way that successive administrations strove to keep the cost of care down - despite changes in the name of the hospital intended to reduce the stigma attached to its inmates, the cost of their care never had parity with patients in general hospitals.

The low priority of Friern long-stay patients was also seen during both World Wars when their beds were needed for the war-wounded, staff for the war effort with the resultant negative effect on opportunities for employment, and their social life was 'suspended'. Further, during the closure programme, little consideration was given to the effect of

the running down of hospital services on the older and most disabled patients still waiting to leave. The negative effect of this disruption must have increased with the hospital fire and the proposed early closure.

It has yet to be established whether Friern patients would be the same low priority once they moved to the community.

3. From the history of Friern Hospital, it can be seen that an act of policy does not always have the immediate desired effect. For example, the expectation of early and milder cases as a result of the new categories of voluntary and temporary patients introduced with the Mental Treatment Act (1930) was not realised at Friern until 1953. Further, the recommendation of this Act that every mental hospital have a separate unit for recent cases was not put into practice at Friern until 1958 with the building of Halliwick House.

An act of policy may also have contradictory effects. For example, as a result of the 1959 Act, the walls around Friern began to come down, the Main Gates and 'the sentry' were removed, and the desire to upgrade the hospital environment gained momentum. However, the 1959 Act also emphasised the reorientation of mental health services away from institutional care to community care, so whilst attempts were being made to improve the hospital environment, the rehabilitation of long-stay patients was also being encouraged.

The effect of the policy of hospital closure and care in the community has still to be established.

4. Many nurses at Friern had shared the impoverished hospital environment with patients for a very long time and had little opportunity for retraining. However, nursing staff were not properly consulted about the feasibility of closure and they did not officially find out that the hospital was going to close until the television announcement.

Although NETRHA had recognised that staff's anxieties about closure should be allayed since the implementation of the closure programme depended on their cooperation, they were not initially kept well-informed about closure plans and given an early commitment to alternative employment. The resulting negative effect of all this on nursing staff turnover, morale and standards, and attitude to new workers seems to have been a very unhealthy basis for the implementation of the closure programme, and must ultimately have increased the anxiety and progress of the patients in their care.

5. As a 'total institution' Friern was an ideal setting for the practice of psychiatry. Since psychiatrists had had their powers restricted under the 1983 Mental Health Act, it could be argued that those psychiatrists who were anti-closure because of their concern for the welfare of the mentally ill, especially if they became homeless, were equally concerned about the prestige attached to their own profession, which would be further eroded unless they could preserve this haven to psychiatry. However, their concerns

about the welfare of the mentally ill may prove justified when Friern finally closed.

6. If admission rates, as a measure of need, had been taken as an 'indicator' of the feasibility of closure, Friern may not have been so easily identified as one of the hospitals which should close. In the long history of Friern Hospital, the demand for admission had always exceeded the number of beds available and, no more so, than during the closure programme.

A significant number of the first long-stay patients to leave Friern had to return to hospital for short periods due to mental deterioration. Since the first leavers were reported by TAPS to be the less disabled of the total population to be discharged, it is likely that there will be an increased demand for admission in the future. However, since psychiatric units of the DGHs were unable to cope with the demand for largely acute admissions, before the closure of Friern, it is unrealistic to expect that they will be able to cater for the hospital needs of the ex-Friern long-stay patients in the future. They, like other people with mental health problems may find it difficult to find a 'community' which, like Friern, will provide for all their basic needs (safety, shelter, food) and care from a variety of specialists on a 24 hour basis when their problems pose a threat to life - their own or others, unless they or their families can pay for private 'asylum'.

The Victorian response to the demand for admission was to keep large numbers of mentally ill people in workhouses

and prisons which were ill-equipped to cater for their needs. With the closure of Friern the modern-day equivalents may, as those who were anti-closure feared, be the streets, hostels for the homeless, and prisons, and the negative effects of these on the mentally ill have already been well-publicised.

7. The patients in Colney Hatch Asylum were forced to remain in hospital and the modern-day Friern patients were forced to leave, as a result of the closure decision. Neither had any 'choice', so the passing of time with regard to taking patients' views into consideration has not been synonymous with progress. If Friern had had a Patients Council, patients may have been able to voice their opinions about the closure during the consultation process. In the absence of this, did patients have any choice about their destination in community?

8. The first inmates of Colney Hatch were out of the sight and mind of the public because the surrounding area was uninhabited. There was a tolerant population around Friern because all the residential areas in the vicinity had grown up around the Hospital, and the area had never been densely populated. However, the attitude of the communities playing host to Friern patients is unlikely to be so favourable to people who were once 'banished' to Colney Hatch and who may be 'noticeable' in 'built-up' areas because of the symptoms of schizophrenia, social behaviour problems, and disabilities caused by long-term institutionalisation and

the side-effects of drug therapy, which may also make them very vulnerable.

Not only was Friern Hospital located in huge grounds in an area which had never been densely populated, but within the hospital, patients had lived in very close proximity to each other. Most accommodation in the community, although 'luxurious' compared to Friern, does not have the same sense of external space and internal social proximity. Some long-stay patients may, therefore, find it very difficult to adapt to living in the community environment.

9. Long-stay patients leaving Friern may be 'stigmatised' because of the history of the hospital. This is because people living in the areas served by Friern are likely to have inherited an image of Friern Patients as being paupers, incurable, unwanted, and dangerous. If this image leads to intolerance, lack of understanding, fear, and hostility towards those bearing the 'ex-Friern' label, not only will their settlement and integration in the community be impeded, but they may fulfil people in the community's worst expectations of a closure programme about which they were not consulted.

10. Some patients had been in Friern for so long that they may have had little or no memory of the communities from whence they came. Others may have been returning to communities in which their conflicts arose and were perpetuated, or which they had never known. In Friern, patients were 'with their own'. It was 'acceptable' to

cadge cigarettes, and they were not ridiculed for odd behaviour or appearance.

The allocation of money to ensure that patients were 'properly dressed' in the community suggests that it was anticipated that what had been acceptable in the hospital may not be tolerated in the community. Therefore, in the absence of returning to a 'known' or tolerant community, Friern long-stay patients, like those known to the Rev. Hawkins, would need friends in the community and, due to their multiple disabilities, they would need people to 'befriend' them. However, it is unknown whether 'befrienders' were available.

11. Opportunities to engage in recreational and social activities had been an enduring and positive feature of the life of patients in Friern Hospital. It was the sheer size of the Friern population which made it financially possible to organise a wide range of entertainments for patients. It is not possible to organise similar social activities for small groups in the community at such a low cost and, as a result of financial difficulties, it is unlikely that providing money so that ex-Friern patients could have 'fun' in the community would be a high priority for Health Authorities.

Work had also always been a positive feature of life in Friern and if the move to the community is to be regarded as progress, the positive elements of hospital life have to also be available in the community. There did not appear to have been enough opportunities for work, and/or the desired



forms of work in the community, as seen by the return of discharged patients to attend the South Workshop. Returning to Friern on a regular basis is likely to have been an impediment to them settling into the community.

When Friern finally closed, and in the absence of opportunities to engage in work and social activities, some patients may feel that they have 'lost out' by their move to the community.

12. The successful discharge of the majority of long-stay patients shows that they could have left Friern years ago, if they had had somewhere to be discharged to and they had been the subject of intensive rehabilitation. Thus, the decision to close Friern may be regarded as a positive one with regard to long-stay patients because, if the hospital had not been targeted for closure, many would have died there. However, in the absence of specific directives from NETRHA to the DHA's on what 'community care' should entail, it is uncertain what community care will mean to Friern long-stay patients who have been discharged and whether they will receive 'equality of care' in the different districts.

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## C H A P T E R 8

### PROJECTS, PROCEDURES, PROFESSIONALS, & EVENTS

#### INTRODUCTION

The purpose of this Chapter is to look in detail at Islington's Friern closure programme and to set the scene for the accounts of the ex-long-stay patients interviewed which appear in Chapter 10 by discussing the residential projects in which they lived, professionals who were directly involved in their movement from hospital to community, and procedures, systems, groups and events which were relevant to this process.

The findings presented in this Chapter are derived from the following sources which were discussed in Chapter 4:

- (a) Interviews with professionals listed in *Appendix 4.1*.
- (b) Attendance at the Adult Care and Clerkenwell Project Group Meetings, Ward Presentations, and the Aberdeen Road Residents Meeting.
- (c) Policy documents, reports, and the minutes of meetings supplied by the voluntary and statutory organisations involved in Islington's Friern closure programme.

Reference should also be made to *Appendices 4.2, 4.3, and 4.7* which list residential projects for long-stay patients (non psychogeriatrics and psychogeriatrics) and centres and 'drop-ins' in Islington and also the map in *Appendix 4.17* on which these projects and other facilities are plotted.

## THE STATUTORY PROFESSIONALS

### The Islington Social Work Team

Before the closure announcement, LBI SSD's Social Work Team (SWT) which was based at Friern Hospital consisted of three social workers and a Team leader who moved between Friern and the Whittington Hospital's Psychiatric Wing, which was a base for another three social workers.

In line with LBI's policy that social workers should 'follow through' with clients, patients who had had social workers before coming to Friern retained these, and members of the SWT at Friern were attached to patients who had previously been 'unknown' to the SSD. As well as their work with acute patients, the rehabilitation of long-stay patients was an important part of the Team's work and they did manage to move a small, but steady, number out of hospital.

In 1983, as a result of the decision to close Friern, IHA agreed to joint fund, with LBI SSD, two additional social workers to the existing Team to specialise in rehabilitation work to enable patients to move out. These two workers devised the form for the assessment of long-stay patients and were part of the original assessment team.

In 1985, another social worker joined the Team to specialise in work with the elderly. This appointment was made in recognition of the increasing numbers of elderly patients in Friern, and not specifically to facilitate their movement out of the hospital. This worker initiated the assessment of psychogeriatrics and later became part of the

Core Team for the Elderly, based at the Archway Wing of the Whittington Hospital.

After the closure announcement, the female-dominated SWT continued to work with acute patients, but about 30% of their work was with long-stay (non-demented) patients in the closure programme to whom they were attached - they prepared them individually or in small groups for the move to the community by way of, for example, shopping trips. In addition, they had a liaison function with particular wards, housing projects, and the Transitional Team (TT). They attended Wards rounds and meetings of the Project Groups. From 1990, under a new Team leader and when all the original members had left (although the new Team leader was a 'returned' original member), members of the Team were attached to patients on the basis of the project they had moved, or were moving, to.

The SWT expected to remain at Friern until all the Islington patients had moved out, when they would either become part of the North and South Islington SWTs working closely with CPNs, or be based in one of the Community Mental Health Resource Centres (CMHRC) in the borough. However, in January 1992, the SWT had to move to the Whittington Psychiatric Wing, where their future was under threat as LBI's SSD strove to make financial savings.

#### The Transitional Team

The TT were appointed in January 1988 to facilitate the movement of patients out of the hospital, by working alongside nursing staff. The TT consisted of six female

workers employed by IHA, who were based at Friern Hospital, in Fellowship House. Some members of the TT had links with Friern before their appointment, for example, through work with MIND, PRA, and PBT. The TT adopted a generic approach.

Each member of the TT had a link with a housing project, and an attachment to a ward. They were part of the Ward Team and attended Ward Rounds and meetings of the Project Groups. They worked with nurses updating patient assessments and on the more intensive work with patients, individually or in groups, to prepare them for the move. They ran art, cooking, and discussion groups to help patients with social skills. They also worked with Occupational Therapists to care for the needs of individual patients and with members of the SWT on the setting-up of a Case Management System.

Before the appointment of the Community Mental Health Resource Team (CMHRT), they also supported patients who left hospital by meeting them to talk, and taking them out. After the CMHRT's appointment, they did the more immediate work with new movers and were expected to hand over to the CMHRT after approximately six months. When Friern closed, the TT expected to be redeployed in Islington, as agreed when they were appointed. By 1991, three members of the TT had taken up community posts - Hornsey Road Manager, Residential Services Manager for Hanley Road and Cornwallis, and Social Facilities Coordinator at Hanley Road.

### The Community Mental Health Resource Team

The CMHRT were appointed by IHA in January 1989. In the first instance, the CMHRT was to focus on people in the Friern closure programme. Their brief was to provide ongoing support for those who had moved out of the hospital and aid their integration into the community. In this endeavour, they sought to identify and deal with problems in the community to prevent readmission, encourage user involvement, educate local people about the needs of users, and link ex-patients to work and leisure facilities in the community. They also offered support and advice to workers in the residential projects.

The CMHRT consisted of four mental health resource workers (3 female) and a female Team leader. Initially a member of the Friern SWT was attached to them for two days a week. Members of the CMHRT came from a variety of backgrounds, and had a wide range of skills and experience in mental health which they had gained, for example, in previous work at Friern Hospital, with the PBT, and the Bloomsbury Community Resource Team. They also adopted a generic approach.

The CMHRT liaised closely with the TT, with whom they shared a client group, and attended Project Group meetings. The CMHRT was initially based in the Royal Northern Hospital in Holloway Road, but in 1991 they moved to a property in Drayton Park which was already a base for CPNs.

An overall aim of the Team was to eventually provide professional community support and resources to all those who experienced long-term mental health problems in



Islington, and it was anticipated that they would eventually be relocated in one of the planned CMHRCs. They would be involved with the development of these Centres by assessing and predicting needs of users and providing information on services.

Community Psychiatrist/Friern Consultant - Dr D Hollander

Dr Hollander worked as a Consultant Psychiatrist at Friern Hospital from 1976 to 1981, when she left to set up mental health services in Zimbabwe. In 1986, she was appointed by IHA to the new post of Community Psychiatrist, based at the Royal Northern Hospital in Islington, to set up services in the community, but she also worked as a Consultant Psychiatrist at Friern. As outlined in Chapter 7, she vehemently vocalised her anti-closure feelings through CONCERN and in her call to retain Friern as a mental health facility, believing that the hospital building and grounds could be used to provide for the growing numbers of homeless people with mental health problems.

Dr Hollander shared responsibility for the care and treatment of patients on Islington's rehabilitation wards and in the day hospital, and for making acute assessments with Dr J Dalton, and Dr J Bruce (part-time). She was in regular contact with nursing staff, the TT, and Friern SWT at Ward Rounds, and shared a community base with the CMHRT. She attended 14 different groups concerning the closure, at district and regional levels, in the hospital and community, and was linked to the PBT and Clerkenwell projects. She regularly saw ex-patients in these projects, and some in

Adult Care. She held a Mental Health Clinic one day a week with a General Registrar in each of the five Health Localities in Islington shown in *Appendix 1.5*. After the closure she would be based in a CMHRC, attending to people there, at Health Centres, and on the in-patient beds of the Whittington Psychiatric Wing.

Friern Consultant/Community Psychiatrist - Dr J Dalton

Dr Dalton had been a Junior Doctor at Friern Hospital before becoming a Consultant Psychiatrist in 1981. From 1988, she also worked as a Community Psychiatrist based partly at the Whittington Hospital Psychiatric Wing.

Dr Dalton had chaired the Team which had planned Islington's closure programme and she welcomed the opportunity for change that the Friern closure brought. She attended 30 meetings per month concerning the closure programme at district and regional level, including an Interim Special Needs Group. She was responsible for half the patients on the admission wards, people on the rehabilitation wards and in the day hospital, and for regularly visiting those who had moved to the Shaftesbury and Cloudesley Road projects, as well as some people in Adult Care.

Dr Dalton liaised closely with members of the TT, Friern SWT and those members of the CMHRT who were attached to projects whose residents she was responsible for, and the Team Leader. She supervised preparatory work for the move and reviewed medication. After the closure of Friern,

Dr Dalton would be responsible for three admission wards at the Whittington Psychiatric Wing.

### Nursing Staff

The reaction of nursing staff, in general, to the closure announcement and the effect of the closure on them was discussed in Chapter 7.

Islington's Senior Nursing Officer had been involved in closure plans as a member of unit, district and regional liaison committees. The Royal College of Nursing (RCN) began operating at Friern Hospital in 1986 and by 1990, there were approximately 100 members. The Branch Secretary, was a Ward Manager (Charge Nurse) on Islington Ward 2 who had been working at Friern since 1964 in different districts, and in Islington since 1987. RCN members had been involved in discussions on issues which affected patients at district and regional level. They had not actively opposed or sabotaged the closure but had expressed concern about the speed at which it was being implemented, and found it difficult to attend meetings because of shift-working.

In September 1987, IHA's Personnel Manager, Priority Services Unit (PSU) coordinated the first formal interviews with all those who had given Islington as their first or second choice, in response to the letters sent out by Hampstead Health Authority, in its capacity as the managing district of Friern. During these interviews, staff were given some information about the closure programme and employment in the community and interviewers tried to

ascertain which members of staff wished to be redeployed in the community, and would be suitable for this via the completion of Person Specifications for an Enrolled Nurse, Charge Nurse, Staff Nurse and Nursing Assistant (see *Appendix 8.1*).

When the first round of interviews had been completed, staff were sent information on all the projects in the pipeline and asked to give their preferences. In 1987, IHA appointed a Friern Assistant General Manager/Professional Consultation Executive for Nursing, who had a base at Friern and at the PSU in Islington. He conducted a second round of informal interviews for clarification and to further ascertain suitability. People were usually considered unsuitable if they fulfilled more than one of the following criteria: inflexibility with regard to working hours; holding general rather than psychiatric nursing qualifications; and, extreme opposition to community care. By June 1990, these interviews had been completed and the majority of staff had been offered a firm commitment to employment. The order of interviews and being given a firm commitment to employment tended to take place according to the time spent working for IHA.

As part of the Ward Team, nurses were involved in the original assessments of patients, and they liaised with workers from the managing agents of the first projects to become operational. From 1989, they had information on the progress of the closure programme through the publication 'Changing Times' and Ward Presentations, which are discussed below. When patients were being considered for the

Clerkenwell project, they began to attend Project Group meetings. Nursing staff were also involved in preparing patients for the move, and had frequent contact with members of the TT, Friern SWT, and Consultant Psychiatrists. They only had occasional contact with the CMHRT when Nursing Officers visited facilities in the community, or at Project Group meetings.

Islington closed wards more quickly than other districts which increased the workload of their staff. There was much 'poaching' of Islington staff because of IHA's delay in offering a commitment to alternative employment. This delay was due to the first projects being managed by voluntary organisations, since they had made their own staffing arrangements, and also to an under-estimation of the time taken to conduct the second interviews.

Hampstead was the most popular district with Islington staff because of its strong leadership and because it opened projects quickly. Haringey was also popular because, for the many staff who lived near Friern, it was less time-consuming to travel to this 'community'. Also, these districts had more accommodation to offer staff, and did not insist on rotational shifts which allowed for training and development. The staff shortage problem on the Islington wards was never resolved even with the employment of Agency staff and this, coupled with the other problems discussed had a resultant negative effect on morale and standards.

All Islington nurses who appealed against being given a Grade F were granted a Grade G which was required for some

senior posts in the community. All Islington staff to be redeployed in the community took part in a two month intensive training programme for the Staff Team for the project they would be working in, before the project opened.

#### CLOSURE PROCEDURES, POLICIES, AND MEETINGS

##### Progress Review Group

The Progress Review Group (PRG) met monthly in the Conference Room, New Nurses Home, St Mary's Wing of the Whittington Hospital until December 1989. It discussed a variety of issues relevant to the closure programme, with an emphasis on the 'progress' of projects. It was attended by members of the Friern SWT, TT, CMHRT, Friern Consultant/Community Psychiatrists, representatives of IHA PSU, LBI's SSD, and the voluntary organisations.

##### Rehabilitation Task Force

The Rehabilitation Task Force (RTF) met monthly in the Olive Room of Friern Hospital and discussed issues concerning the welfare of patients and ex-patients in Islington. The Task Force was chaired by the Leader of the Friern SWT and consisted of the same professionals who attended the PRG. However, it was also attended by representatives of the Islington Community Health Council (CHC), IMHF, and nursing staff. It was, therefore, considered to be an important platform for people with little or no direct input into other groups.

In June 1990, the RTF considered the proposal made by Mr D Manion, Islington's Assistant General Manager of Friern that the RTF should have a tighter management structure

and/or that it should combine with the PRG, which had not met since the PSU had moved from the Whittington Hospital site to Insurance House, IHA's administrative headquarters in the south of Islington, since the RTF and PRG appeared to have duplicated functions. In the absence of Mr Manion, it was decided that the RTF should continue in its present form with more clearly identified functions. The RTF continued to meet but with no formal agenda or minutes and Mr Manion continued to be sceptical of its effectiveness other than being useful for exchanging ideas.

#### Islington Ward Rounds at Friern

Ward rounds took place once a week. These were attended by: Friern Consultant Psychiatrists; Junior Doctors; Nursing Staff; Members of the Friern SWT and TT; and, sometimes other invited people, such as a community-based social worker already attached to a patient. During the Ward Rounds, patients were discussed, either all briefly or a few in detail when they were short-listed for a particular project.

#### Case Coordination System

This system was set-up by the Friern SWT and TT, and was implemented in January 1990. Under this system each patient in the closure programme was allocated to a member of the TT or SWT. This person had to ensure that their care plan and all the paperwork concerning their move to the community was completed. After two months the two Teams would meet to review their progress. Eventually, all patients who had been part of the closure programme and were already living

in the community would be allocated a Named Worker who would be responsible for coordinating reviews of their progress and be the first point of contact when problems arose or in times of crisis.

#### Planning Permission

Planning permission was required in Islington when a property changed its use and became a 'residential institution', that is, it provided residential accommodation to more than six people, and when there were alterations to the exterior structure, for example, ramps for wheelchair access.

#### Operational Policy and Memorandum of Agreement

Apart from the Adult Care project which had a 'Contract' setting out the terms and conditions of the placement between the carer, client and the LBI, each residential project established as part of the Friern closure programme had an Operational Policy (OP) and Memorandum of Agreement (MoA). The OP described the site and accommodation, and set out the philosophy, aims and functions of the project, its organisation, management, funding, support services, maintenance, fire, and security conditions, and staffing levels. It also stipulated the client group it would accommodate and any exclusions, criteria for selection of residents and their occupancy rights.

The 'Contract' for the Adult Care project appears in *Appendix 8.2*. The OPs for the next four residential projects in Islington for long-stay patients (non-psychogeriatrics) supplied by the managing agents (PBT,



MIND, PRA and LBI's SSD) appear in *Appendices 8.3 - 8.6*.

All the ex-long-stay patients interviewed lived in one of these projects.

The MoA gave the title of the project, name of managing authority, source of finance, capital and revenue grant details and future funding requirements. It listed the objectives, benefits, what was being provided, admission criteria and procedure, organisation and management arrangements, and supporting services. It also specified the proposed start date, patients start date, mechanism for monitoring and proposed review date.

Certification of a project took place when the MoA was signed by the Health Authority (HA) and the Managing Agent of the project, and a project could not proceed without a signed MoA. Managing agents generally selected their own staff, but the HA had to approve the appointments. If the services provided by the body receiving payment in respect of the project were reduced, the payment was reduced accordingly. Although some managing agents had their own monitoring procedures, the MoA stated that the HA was responsible for monitoring the project. However, it was 1991 before all operational projects had at least an annual review. (RTF Meeting 3/91)

#### ASSESSMENT AND PROVISION FOR PSYCHOGERIATRICS

Elderly long-stay patients suffering from dementia were assessed by Dr C Katona and his Core Team for the Elderly.

Dr Katona's assessment unit, consisting of five beds and day places, was temporarily based in the Archway Wing of

the Whittington Hospital. It was expected that it would move to the Highgate site of the Whittington Hospital, called Highgate Parkside, where a planned facility funded and managed by IHA and consisting of a 14 place day and residential assessment unit, 20 place day hospital, and special needs unit with offices above for a community team (later abandoned to save money) would become operational in October 1991.

Decisions on the placement of psychogeriatrics were made by a Bed Bureau consisting of social workers, nurses, and medical staff on the basis of these assessments. However, decisions were not made until projects were about to become operational due to the high turnover of patients in this group because of death, and the equally high demand for places.

In 1986, IHA and LBI SSD agreed that 80 psychogeriatrics should be moved into two long-stay 'Nightingale style' wards and five new-build bungalows on the Highgate Parkside site. Initial plans for psychogeriatrics on this site, however, were seriously delayed because of a formal disagreement between IHA and the CHC. The latter strongly opposed the afore-mentioned plan on the grounds that it was high density hospital-based reprovion, and suggested small staff units throughout Islington, as an alternative. The matter was referred to NETRHA and the Secretary of State.

While a decision was being awaited, Dr Katona's Team undertook a survey of the needs of psychogeriatrics and concluded that only 60 hospital beds would be required, 40

on the Highgate Parkside site, and 20 elsewhere. The remaining 40 would be able to live outside a hospital environment.

In 1987, the Secretary of State upheld the CHC's objection, and echoed the recommendations made by Dr Katona's Team - that only 40 should be accommodated on the Highgate Parkside site. The accommodation was to consist of a cluster of five newly-built units, each housing 7/8 people with 24 hour nursing staff. Thus, each unit would be similar to the accommodation for psychogeriatrics at Highbury New Park and St Anne's which was proving successful.

In 1987, IHA and Anchor Housing Association explored the possibility of converting Naish Court (an outmoded sheltered block owned by LBI) into a 52 unit residential site to house 20 low dependency psychogeriatrics from Friern and 32 frail elderly people from Islington. However, in a report dated 22nd March 1988, the Committee noted the problem of decanting the stable community of residents and questioned whether psychogeriatrics from Friern could live side-by-side with the physically frail from Islington.

Eventually negotiations to acquire Naish Court broke down because LBI considered Anchor Housing Association's record with Unions to be unacceptable. Also, NETRHA did not have enough money to develop the whole Highgate Parkside site, and the planned accommodation for psychogeriatrics there was cancelled in 1990.

As a result, alternative plans for psychogeriatrics had to be made and provision for them was seriously delayed.

This meant that a large number of psychogeriatrics were among the long-stay patients who were the last to leave Friern, and they went to high-density and some hospital-based accommodation in Isledon Road and at St Pancras. However, St Annes, Highbury New Park, and Aberdeen Road provided homely, high quality accommodation for small groups of psychogeriatrics and the new-build scheme at Isledon Road, albeit high-density, was also vastly superior to the environment psychogeriatrics had had to endure in Friern.

#### THE ASSESSMENT OF LONG-STAY PATIENTS (NON-PSYCHOGERIATRICS)

Long-stay patients (non-psychogeriatrics) were assessed by a multi-disciplinary group which had produced a detailed form for this purpose. The assessment involved interviewing the patients themselves and the staff caring for them, to find out what sort of care they would require in the community.

It was originally envisaged that the assessment process would be finished by the end of 1985, but the patient assessments were not finally completed until February 1987 because they were beset by problems. The form used was so detailed, it took much longer to complete than anticipated and some patients required a number of interviews before they were able or willing to cooperate. The time taken to go through the hospital files was also longer than expected and the number of people available to do this was insufficient. Further, the OT and CPN promised by IHA to facilitate the assessment process did not materialise and one of the two full-time rehabilitation social workers became part-time and then they both left their posts.

These assessments were carried out with no input of a racial or cultural nature, and there had never been any systematic ethnic monitoring of patients on the Islington wards of Friern. However, early in 1986, this oversight began to be remedied when a member of the Friern SWT carried out a survey of the ethnic background of the majority of patients (excluding psychogeriatrics because very few came from minority ethnic groups), for the purpose of carrying out preparatory work necessary to meet the deadline on registration for British Citizenship in 1987.

This survey indicated that of the 151 long-stay patients occupying Islington beds, 57 (38%) were other than white British. The main groups represented were: 10% Afro-Caribbean; 7% Irish; 4% Greek Cypriot; and, 3% Nigerian. There were also six patients from the Asian subcontinent. On the admission wards, 56% were not white British.

This survey showed the importance of race when planning the move from Friern to Islington. As a result LBI's Race Policy and Practice Adviser became involved in discussions with minority ethnic groups in the community with regard to incorporating ethnic and cultural differences into the plans for discharge, for example: by linking patients and ex-patients with ethnic minority organisations in the community; matching patients and Adult Carers on racial and cultural lines; and, setting-up group homes and support groups at Friern and in LBI's Day Centres based on ethnic groupings.

Employees of IHA and LBI SSD generally thought that the original assessments of patients were valuable for a number

of reasons. The only prior source of information on patients was case notes which were often difficult to read, and relatives, nursing staff, and social workers had all been involved in the assessment process. Also, the assessments enabled planners to look at the balance of residential and day care, and the need for structured, informal, and specialised provision, and some plans changed as a result.

However, they acknowledged that there were problems with these assessments. Some plans had been made before they were completed, they very quickly became out-of-date, and there had been no systematic re-assessment of patients, the original assessments tending to be up-dated as patients were being considered for projects. Also, they did not include OT assessments and the CMHRT did not have access to them.

With regard to the voluntary organisations, PBT were sceptical of the value of the patient assessments and this proved justified, since only three of the original ten patients identified as suitable for their project from these assessments actually moved there, and they had two long-term vacancies. MIND also questioned the usefulness of the patient assessments because they became out-of-date so quickly and because their workers did not have access to them, which made the selection process for the Shaftesbury Road project difficult.

PRA appeared to regard the patient assessments as valuable because they legitimized the list of potential candidates for the Cloudesley Road project made by their

representative, after activation sessions on Wards 2 and 5. However, since only four of the people on this list actually moved to the project and there was one long-term vacancy, they were perhaps not as valuable as first thought.

#### INFORMATION ON THE CLOSURE PROGRAMME

##### The Publication 'Changing Times'

In 1989, a small group of people from IHA, LBI's SSD, and IMHF began producing a monthly newsletter entitled 'Changing Times'. This gave details about the progress of closure projects, new workers, and general information about facilities in Islington. This was distributed to people on the Islington wards, the Whittington Psychiatric Wing, in operational projects, and Day Centres and, although intended to give patients and ex-patients up-to-date information on the closure programme, it was also useful for keeping staff working with them, especially nursing staff, in touch with the latest developments.

##### Ward Presentations

PBT, MIND and PRA all made presentations about their projects on the Islington wards in an attempt to identify patients who were suitable for their projects and who were willing to move there.

As outlined in Chapter 4, the researcher took part in Ward Presentations organised by LBI's SSD in January and February 1989 and a Grand Presentation in March.

Posters advertising the Ward Presentations were given to Charge Nurses to display on Wards, but some had not been displayed. Similarly, the 'presenters' reported that some

nursing staff were helpful in rallying patients to attend the presentations and seemed interested in them whilst others did not help at all, and left whenever they began.

The researcher personally attended two Day Care, one Clerkenwell and one Adult Care presentation on each of the four wards. She found the all-male wards to be very quiet compared to the very noisy all-female wards. The presentations were attended by approximately a third of the patients on each ward, but some moved around a lot, or wandered off completely. Staff on two wards rallied patients to attend and one member of staff attended the presentation on one ward.

Patients were extremely interested in opportunities for work. They mentioned work they had done before (painting and decorating, typing, cleaning), work they did in the Workshops (knitting toys, packing confetti), and were enthusiastic about learning new skills and earning money.

Some patients and a member of staff were interested in the photographs and plans for the Clerkenwell project and asked questions about the staffing levels and the local area. However, some of the patients showing an interest in the Clerkenwell project looked elderly and physically frail and it was unlikely that this project could provide for their needs.

A 'personalised' talk given by an ex-Friern patient in Adult Care, was very well-received by patients who were temporarily housed on the Halliwick site, as a result of the fire. It prompted jokes, questions, and created a very



friendly atmosphere between presenters and patients. The researcher noted that this ex-patient was a person who was expected to move on to independent living but who later became depressed and required intensive medical and social support.

Some patients did not believe that the hospital was going to close so they, therefore, did not think that they would have to move, and some thought that they had been there for so long that nothing should be expected of them in the community.

The Grand Presentation was well-attended by professionals who had taken part in the Ward Presentations, as well as Psychiatrists, representatives of IHA's PSU, and people from the Clerkenwell community. There was also a steady flow of patients who particularly enjoyed the tea and biscuits and activities organised by IHA's Employment Development Officer (pottery, potting plants, and computer games) as an example of what the Pine Street Day Centre was offering.

These presentations were the first of their kind and considered to be a 'success' by professionals and, therefore, worth repeating.

#### SELECTION OF LONG-STAY PATIENTS

Employees of IHA, LBI's SSD, PBT, and MIND all showed sensitivity to the rights of patients with regard to selecting them for projects in the community, for example, by suggesting that they sign their assessments as an indication that 'others' could see them, by consulting them

about the circulation of their Individual Programme Plans, by ensuring the confidentiality of Project Group minutes, and by giving them access to their Discharge Summaries and other records. However, professionals were largely sceptical of the ability of patients to choose their destination in the community.

The researcher made a number of observations with regard to the selection of patients from secondary data, interviews with professionals, and attendance at Project Group meetings.

There was an operational problem in the selection of patients in that IHA had nomination and veto rights, the managing agents had the right of selection, and the final selection to discharge patients lay with Friern Consultants. This was exacerbated by the lack of established Terms of Reference for the Project Groups - each Group defined its own.

Patients were not represented at Project Groups meetings, very little priority was given to their opinions about moving to a particular project or to providing the type of project they requested. For example, a group of women expressed a desire to move to an all-women project to MIND workers but a project of this type never materialised. Generally, if patients were considered suitable for a project but did not want to move there, they remained on the list of possible candidates. Similarly, if patients expressed an interest but were not considered suitable, they were removed from the list.

There was no real uniformity of information on patients which made comparisons and decisions difficult. Also, there was little information on why patients had previously been rejected for projects, which could have been useful to later Project Groups.

Patients were frequently rejected for projects if they were being considered for other projects. However, some of these projects did not materialise and some of the patients did not move there. Some patients were continually rejected for projects for which they had taken part in rehabilitation work, which must have led to a sense of failure and disappointment.

The problems of physical health and social behaviour identified by TAPS (see *Appendix 1.7*) which could be attributed to the natural ageing process, their illness, the side-effects of medication and the negative effects of long-term institutionalisation and neglect were evident in many patients being selected for residential projects. They were the focus of rehabilitation work and the failure of Individual Programme Plans which precluded patients from moving to projects showed just how serious they were. The shock and resistance of some patients to rehabilitation work showed that this had previously not been an option for them. Communication and mobility problems, poor self-care, incontinence, bizarre behaviour and dress, and the fire-risk caused by smoking were frequently mentioned because they would be more difficult to deal with in the community setting, projects did not have the physical environment or

support to deal with them, and because they would make patients very visible in the community.

There were many instances of patients with families who proved particularly problematic with regard to moving them to projects in the community and although Guardianship was suggested, it was not followed-up.

IHA's Clinical Psychologist seemed to have considerable power in the selection of patients for all projects by virtue of his first-hand knowledge of patients and his position as IHA's representative. However, PBT, PRA, and MIND had considerable power in the selection of patients for their projects, in the absence of other professionals.

The only real challenges to IHA Clinical Psychologist's opinions on patients at the Clerkenwell and Adult Care Project Groups came from ACOs, members of the Friern SWT (especially the male member), and the Community Psychiatrist/Friern Consultant on the rare occasions she attended. Members of the TT and CMHRT although facially showing their disagreement, did not verbalise their objections probably because they were relatively new Teams and also IHA employees. The SWT seemed to 'take the middle ground' between IHA and their colleagues from LBI's SSD, probably because of the effect of working within the hospital environment.

Patients who had 'champions', for example, known personally to IHA's Clinical Psychologist, linked to members of the TT and SWT, and particularly favoured by representatives of the voluntary organisations, seemed to have a better chance of being selected for projects. At the

Clerkenwell Project Group, the more withdrawn patients did not seem to have 'champions', perhaps because rehabilitation workers did not have the time to spend with them to find out if they would be suitable.

Workers involved in the rehabilitation of patients were under a great deal of pressure, as seen in their inability to carry out tasks delegated to them by the Adult Care and Clerkenwell Project Groups. However, there seemed to be a great deal of duplication of work by individual members of the different Teams.

The Adult Care and Clerkenwell Project Groups did not adhere to their Terms of Reference. The former were particularly lax in discussing the progress of those already living in Adult Care and the latter in not making the Neighbourhood Officer account for and deal with staffing problems which occurred because she had 'omitted' to send out advertisements for the Senior staff posts and which escalated to such an extent that the project was delayed for six months.

Clerkenwell was intended to be a mixed-sex project but it became an all-male project because the Project Group had been unable to secure permission for the conversion of Ward 13 to a mixed ward from the Hospital Management. This effectively excluded women but, the unexpected appearance of the Cornwallis project salved the consciences of the Project Group because they could divert suitable female candidates there. In view of the delay in the operational date of the project and its financial consequences for IHA, emphasised

by IHA's Clinical Psychologist, concerns about the problems of having an all-male project faded into the background.

Ward 2 may have been a more appropriate ward for the Clerkenwell project since most of the potential candidates were originally on this ward, and it had mixed sex facilities. This would have cut down on the anxiety caused by ward moves, which for some proved too much and effectively excluded them from the project, thus creating vacancies.

Six months before the operational date of Clerkenwell, the Project Group moved to Ward 13 so that it would be easier for nursing staff to attend. This heralded the beginnings of a good working relationship between all the workers involved in the rehabilitation of Clerkenwell patients - nursing staff, TT, SWT, and the CMHRT. This may have been because priority had been placed on involving nursing staff and because they had, by then, been offered a firm commitment to employment in the community.

The Adult Care project was financially attractive to IHA but it was unable to reach its target of first 60 and then 20 patients. This was probably because there had not been a carers recruitment initiative since the scheme had been set up in 1984 and it was proving difficult to find carers 'who would really care' for people with mental health problems, albeit that they were paid a generous amount to care. Many of the carers who had come forward were outside Islington, the majority were in the Friern area, and some were ex-Friern nurses. Some people who had moved to Adult

Care still had social workers who were part of the Friern SWT.

Patients had not been matched with carers according to their minority ethnic group. However, ACOs insisted that an Asian patient could not refuse a black carer because this would be in contravention of LBI's Equal Opportunities Policy. Adult Care Reviews took place in the presence of the carer which may have made it difficult for ex-patients to 'complain' about their care. The exclusion of psychiatrists from Adult Care Reviews may have been detrimental to the progress of ex-patients, as seen in the person whose psychotic symptoms had escalated to such an extent that he had to return to hospital.

There were disagreements between IHA's Clinical Psychologist and ACOs on the suitability of patients for Adult Care with regard to what could be dealt with in this project. For example, the former thought that the clinical condition of a man with obsessional 'touching' behaviour could not be changed, whereas the latter thought it could be dealt with in a community setting.

#### THE ISLINGTON WARDS OF FRIERN HOSPITAL

A description of the composition of the Islington wards of Friern as at October 1989 is contained in *Appendix 8.7*. This shows that Ward 16 for acute patients was locked as were all the elderly wards because other forms of containment had been unsuccessful. It also shows the small overall ratio of staff per shift to patients (1:11) on the

rehabilitation wards which was problematic given that the focus of the work of nursing staff was now rehabilitation.

There was only one mixed sex rehabilitation ward which was also problematic as wards increasingly became designated as project wards, projects strove to have a mix of sexes, and the hospital management refused to provide mixed sex facilities on the other wards. Evidence of this was shown with regard to the selection of patients for Clerkenwell which became an all-male project.

There was a need to move the growing number of patients in the Whittington Psychiatric Wing with more than a year's continuous admission to Friern, and then to closure projects, so that the Psychiatric Wing could become an acute facility in the future. (RTF 10/89) However, to effect the closure of Ward 16, all patients on this ward had to be moved to the Whittington Psychiatric Wing by March 1992, even though concern had been expressed about the pressure on acute admission beds and the likelihood that it would increase. (RTF 9/91)

IHA were under constant pressure to close wards at Friern in order to reduce the cost of running services in parallel. Therefore, once a ward became a project ward and the patients selected had moved to that project, the ward closed. This meant that patients who had not moved to the project had to be relocated on another ward. For example, in August 1990, patients who had moved from Wards 2 and 5 to Ward 13, which was the designated ward for the Clerkenwell project, but who had not eventually moved to Clerkenwell, had to move to Wards 2 and 17 when Ward 13 closed, unless



they were being considered for the Hanley and Hornsey Road projects, in which case they would move to Ward 5.

However, there was also a need to re-accommodate people who had returned to Friern because their placement was inappropriate or lacking sufficient support, they had had a natural relapse, or had had problems with medication. According to IHA's Clinical Psychologist, of the 45 people discharged by January 1989, 10 had been readmitted.

It was generally agreed that Special Needs Patients should not be moved prior to leaving Friern. (RTF 11/90) However, in order to adhere to this, and to provide a much needed mixed ward on Ward 2, other patients had to be moved from Ward 2 to Ward 17. However, some of them had previously been moved from Ward 17, and some had had several moves as wards had increasingly become designated as project wards. (RTF 10/91). By March 1991, all hospital wards had become project wards and there were more patients living in the community than in the hospital.

The last two years of the closure programme also saw the accumulation of some patients on Wards 2 and 17 who had proved 'difficult to place' or had been readmitted. There was also a mismatch between some people remaining on Wards 2 and 17 and the operational projects available to them (Caledonian Road and Intensive Rehabilitation Unit). Consequently, six people who had not moved to the Hanley Road project were likely to end up as 'special needs' by default. (RTF 10/91)

### SHORTAGE OF PROPERTY IN ISLINGTON

There was a shortage of property in Islington for closure projects. This was due to the lack of land, the large number of homeless people (especially families), and the range of vulnerable groups competing for accommodation in the borough. Since LBI's Housing Department did not have the financial resources to convert properties which were in a bad condition, they were keen to retain those which could be converted cheaply into family houses, and these were the type of properties required for group homes for people in the closure programme.

Due to the shortage of property in Islington and the competition for this scant resource, the acquisition of a suitable site for a project was a 'hit or a miss' affair, which explains why some planned projects did not materialise. For example, a proposed project for Greek-Cypriot men who wanted to live together in Cheverton Road fell through because the house was not large enough to have 24 hour staffing which the men required.

LBI's SSD acknowledged the desirability of positioning residential projects in communities which were or could become, via public consultation exercises, favourable towards people coming from Friern. However, due to the shortage of property in Islington, they did not have the luxury of looking at the nature of communities around proposed residential projects.

### STAFFING IN RESIDENTIAL PROPERTIES

IHA and LBI SSD employees generally agreed that, ideally projects should have a mixture of Friern and community staff

- the former knew the patients and had experience of dealing with their problems, and the latter knew the borough and could help them to integrate into the community. However, although IHA had to approve the appointment of staff, the managing agents were generally free to recruit the type of staff they considered suitable for their projects. The voluntary organisations and LBI SSD had recruited staff for the first projects before nursing staff had been given a firm commitment to employment in the community and/or were not generally in favour of employing Friern nursing staff because of their institutional background. This meant that the first residential projects did not employ Friern nurses, whereas the later, higher dependency projects did.

#### VACANCIES IN THE PROJECTS

The low level of support in the PBT project and initially having to be part of the work scheme acted as a deterrent to patients wanting to move there. This was because the PBT project was one of the first projects and, since all the patients had not yet been assessed, they were nowhere near being reconciled towards the idea of hospital closure. However, the two long-standing vacancies in the PBT project indicated that either it did not satisfy the needs of patients, or that patients became disinterested due to the delay in the operational date.

The delay in the operational date of the PBT project was caused by the delay in the completion of patient assessments and problems in the selection and preparation process, due to the lack of nursing staff cooperation. The

delay in the operational date of the project subsequently led to the vacant properties being squatted, which caused a further delay in the operational date.

The two long-term vacancies in the PBT project created problems for IHA at a planning and financial level, albeit that the net cost of the PBT project to IHA was very small. However, while IHA was bearing the financial cost of the delay in the operational date and full occupation of the project, PBT had to suffer the moral dilemma of having vacancies in an area with large numbers of homeless people.

Although the MIND project also had a low level of support, this project had no long-term vacancies. This may have been because a project of this type did meet the needs of some patients and/or because the housing support workers were appointed six months in advance of the anticipated opening date, they had no problems gaining access to patients, they had met patients and staff and conducted ward presentations prior to becoming involved in the selection and preparation of patients. Also, the house was open for three months before the residents moved which allowed some preparatory work to be done there and to move the residents in gradually, for example, by overnight and short stays.

There was a delay in the operational date of the PRA project due to problems with the completion and signature of the MoA, and again IHA had to bear the cost of this delay and one long-term vacancy (18 months) in the project which seemed to be because two people had failed to move in due to failing physical health. However, given the high level of support in this project which was preferred by the majority

of patients, PRA's paternalistic attitude may not have been attractive to some patients.

The building work on the properties comprising the Clerkenwell project, like PRA, were completed on schedule but the delay due to staffing problems as a result of incompetence by the Neighbourhood Officer meant that they were vacant for six months before the first residents moved in. In view of the shortage of accommodation in Islington, these vacant properties caused concern from humanitarian, financial and security standpoints - money had to be spent on securing them so that squatters did not move in and IHA did not receive money for bed closures until the patients moved to the project.

The two long-term vacancies in the Bedsits show that this type of accommodation may have been inappropriate for people first leaving Friern in that it was so different to the environment they had been accustomed to that they found it difficult to adapt. Indeed, that was the view of potential candidates for the bedsits which was ignored. However, given the pressure on IHA to close Ward 13 in June 1990, the people moving to Clerkenwell may not have been properly prepared, since there was no mention of short stays before they moved to the project in August.

Other problems may explain the Clerkenwell vacancies. It became an all-male project, the delay in the operational date meant that some patients became disillusioned and disinterested, and some were unable or refused to move to Ward 13. Also, the support staff were only in post two

months before the project opened so they did not know the patients very well.

#### DISAGREEMENTS AND DIFFERENCES

Disagreements and uneasy relationships between statutory professionals and between statutory professionals and workers from the voluntary organisations have already been highlighted with reference to the selection of long-stay patients for projects in the community. However, there were many other differences and disagreements between organisations and professionals involved in Islington's Friern closure programme.

For example, PBT workers did not agree with the Community Psychiatrist/Friern Consultant when she wanted to re-admit one of their residents to hospital since they believed that the problem could be dealt with in the community. They also considered this Consultant's inventory of their residents underwear to be an invasion of their privacy and not a true indication of how they were managing in the community.

Originally MIND intended to have only one worker in their project but IHA considered this level of support to be inadequate. PRA expected to house nine people at Cloudesley Road but IHA objected to shared bedrooms as a permanent feature of the closure programme accommodation. Eventually, IHA agreed to increase the Revenue Grant to fund another post at the MIND project and to cover PRA's shortfall as a result of reducing the number of residents in their project to seven.

IHA's continued concern that MIND had too little control over their residents may have been justified in that 'sectioning, banning, and eviction' were the only solutions to problems which arose in the third year of the project. However, MIND were adamant that IHA should not have control over their project especially since IHA had acquired a home for six people at a low cost to themselves, just as they had with the PBT project.

MIND found the TT to be unhelpful on financial matters, working on the women's wards to achieve a balance of sexes in their project, and providing information on patients. However, both IHA's Clinical Psychologist and the TT disagreed with MIND's medication policy. They were also critical of the institutional practices developing at PRA's project because it had been under-resourced in terms of the numbers, experience, and permanence of staff. This meant that project staff were sometimes unable to develop relationships with some 'demanding' residents and the resulting problems made demands on the TT and Friern SWT which would not be tenable in the future. These practices were in contravention of PRA's operational policy para 11.1 which stated that the project would 'not become a mini-hospital'.

Nursing staff were unhappy about the invasion of their 'domain' by the TT. However, the appointment of the TT alleviated problems for PBT and PRA in dealing with hospital staff but created problems for MIND, who had had a good relationship with nursing staff. There were tensions between the TT and Friern SWT because they were generic and

professionals Teams, respectively, with overlapping areas of responsibility. There were also tensions between the TT and CMHRT which, although both generic Teams, shared a client group at different stages of the preparation and discharge process and the CMHRT found the TT sometimes unwilling to hand over responsibility to them.

The Community Psychiatrist and Friern Consultant had different perspectives on the closure of the hospital and, although they did not admit to having experienced any problems as a result of sharing wards with each other, nursing staff often observed them to be in dispute over bed closures, which added to the burden on nursing staff, and the Project Groups witnessed them disagreeing about the suitability of individual patients for particular projects.

It was unknown whether patients would need the same, more, less, or different medication in the community because the hospital and community were different environments, there may be changes in their clinical condition, and the negative side-effects had to be balanced against benefits. Although patients took part in a self-medication programme before they left hospital, there was no guarantee that they would adhere to this when they moved to the community. Medication was, therefore, the responsibility of project managers. However the project managers had different philosophies on medication. For example, MIND encouraged residents to choose whether or not to take medication and MIND workers would not control or administer medication. In contrast, PRA would control, administer, and monitor medication in the group home.



Although MIND were to be commended for their commitment to the education of patients about medication and its side-effects, they may not have been able to adhere to their policy on medication if they had had to support a higher dependency group. Even MIND workers had a problem when they had to decide between supporting a resident's right to choose where (on the body) they had an injection and their physical welfare.

The difference in philosophy between PRA and MIND did not just focus on medication. MIND allowed residents to choose their own rooms in a group home with a low level of support, where there was an almost over-emphasis on privacy (shown in the provision of six fridges and kitchen cupboards) and the rights of residents, whereas PRA chose residents' rooms for them, in a group home with 24 hour support where the emphasis was on communal living and greater priority was given to the concern of 'outsiders' than the rights of residents.

There were also differences between the adult care project and the group homes. Although some ex-patients could remain with their carers when they deteriorated, their placement would not be a 'home for life' if their carers could no longer cope or died. Patients who had moved to other projects would usually remain in the same accommodation, even when project workers were replaced.

### COMMUNITY MENTAL HEALTH RESOURCE CENTRES

Originally, three Centres were planned, in North, South, and Central Islington, but a suitable site could not be found in the centre of the borough.

The Centres would accommodate a multi-disciplinary Team of workers, appointed on a full-time or sessional basis. This Team would include psychiatrists, psychologists, psycho-therapists, social workers, and health outreach workers. The range of services they were expected to offer were: support and self-help groups; information and advice; assessments, therapy, and treatment; crisis intervention; and, drop-in facilities. The Centres would be used to work with people individually and in groups, to forge links with CPNs and Neighbourhood Office staff, and as a base from which to work out in the community.

The proposed location for the North Centre was Manor Gardens behind the Royal Northern Hospital, and it was expected to open in 1991. However, this site fell through and an alternative could not be found. The proposed location for the South Centre was Ritchie Street, near IHA's administrative headquarters and it opened in 1992.

### DAY, WORK AND SOCIAL ACTIVITIES

IHA recognised the importance of Day Care and opportunities for work and social activities in the community as seen in their funding of an additional worker to the PBT sheltered work scheme, new posts in LBI's Day Centres, their plans for developing new Day Centres, Employment Projects, and Befriending Scheme, specifically for Friern people, and the

appointment of the CMHRT, albeit that this was not until the seventh year of the closure programme.

However, in 1989, LBI's three Day Centres, experienced staff cuts - The Avenue and Pine Street each lost one Senior/Assistant Supervisor post and St Andrews lost two Centre Assistant posts, making the total percentage of posts lost in one financial year, 25%. In a report dated January 1990, the Director of Social Services (Mr J Rea-Price) explained the reason for the cuts. Although the budget for mental health services was the lowest of all the client areas, as part of the Programme Plan for 1989/90, savings of 12% had to be made.

Since LBI's Day Centres were expected to cater for all people from mental health problems in Islington, not just people from Friern, the Director of Social Services concluded that the staff cuts in these Day Centres, due to LBI SSD's shrinking resources, was raising the spectre of a two-tier system for Friern and non-Friern users.

In the interests of preserving the service to users, the Day Centre supervisors agreed not to reduce the number of places, but these cuts did have some very negative effects. Remaining staff reported experiencing a sense of being devalued because the service they had been offering had not been treated as if it was important, and also a sense of loss on the departure of particular colleagues. They were constantly tired and over-stretched because the same amount of work was expected to be done by fewer people, which was particularly serious when staff were off sick, and created security problems.

The remaining three staff at Pine Street felt that they may have to reject the most needy users. After being threatened by intruders, staff at St Andrews no longer felt safe in the building and kept the door of the Centre locked.

Supervisors described themselves as moving from crisis to crisis, never having time to sit back and reflect, and never being on top of their work. None of the Centres had any clerical staff and demands for better record-keeping, management of budgets, and detailed monitoring of staff absences, placed an additional and time-consuming burden on remaining staff which detracted from the time they could spend with Centre users.

Fewer members of staff meant a higher number of users to each keyworker. This was an important post because most service users did not have regular contact with a social worker and had to rely on Day Centre keyworkers for primary support and counselling. Due to the heavy caseloads of social workers based at NOs, they were finding it difficult to provide social work support to ex-Friern long-stay patients even when this support was part of the OP for the project in which they lived (RTF 12/89). This increased the demand for keyworkers at Day Centres which were already understaffed.

More time spent on individual work meant less time spent running groups, and the fewer the groups, the less interesting the programme. If users stopped attending because they were dissatisfied with the programme then the Centres would become more vulnerable to losing further staff.

LBI's SSD had long been concerned that people from minority ethnic groups were under-represented at the Centres. Staff were beginning to make the Centres more attractive to these people by running groups and projects especially for them and offering more varied and relevant food, as seen in the increased number of referrals. Due to staff cuts, however, there was little time to concentrate on these initiatives.

Staff cuts also caused the loss of community initiatives to make the Centres more outward-looking and bring the outside world in. The post lost at Pine Street was created in 1987 to tie the Centre into the local community with the result that remaining staff had to retreat back into the Centre building. The loss of the Centre Assistants at St Andrews meant the dissolution of the Work Coop for local elderly people, the evening groups for the families of users, and leavers, and the Social Club. Plans for an evening group and a Sunday Lunch Club at The Avenue also had to be shelved.

Islington experienced many other problems in attempting to provide day, work and social activities for people coming from Friern. The Southwood Smith Day Centre had been delayed for a year due to pressure to keep costs down and a problem with access. The Hanley Road project, which included a Day Centre, had been delayed for a year due to legal technicalities.

A planned Work Preparation Unit for 20 people had been postponed until 1992 due to lack of revenue (RTF 9/89). Also, the voluntary sector had had little success in

securing work opportunities for ex-patients because they had all been approaching the same employers (RTF 11/90).

It had been difficult to get Friern patients to the IMHF while in hospital which meant that, in the absence of other opportunities to participate as service users, it did not seem immediately appropriate for them in the community (RTF 9/89, 4/90). Although there was an acknowledged need for a Befriending Scheme, this had not been implemented because of inadequate financial resources which made it difficult to find an organisation to manage the scheme or appoint a Coordinator and recruit local people (PRG 12/88; RTF 9/89, 3/90, 4/90, 5/90, 9/90, 1/91).

MIND and PRA both initially encountered problems in providing day care for their residents, and there was a particularly serious problem with the Day Care of the 'first movers' to the Adult Care project because the majority lived in the Friern area. This, coupled with the fact that they received social work support from the Friern SWT meant that they had retained a strong link with the hospital. It was not until September 1989 that arrangements started to be made for them to attend LBI's Day Centres but, due to staff shortages at these Centres, it was difficult to get them in and particularly difficult if they had any additional problems with, for example, speech and hearing, because of the additional input these people required from Centre staff, unless members of the Friern SWT agreed to act as their keyworker.

## COMMUNITY ATTITUDES

The attitudes of professionals varied on the continuum of thinking that any community would be better than Friern to being convinced that community attitudes and conditions were very important, since adverse reactions could act as a barrier to patients becoming part of the community.

In order to protect the right to anonymity of their future residents, the voluntary organisations were generally not in favour of consulting communities, unless this was required to obtain planning permission, and it was only the PRA project which required this. LBI SSD were keen to consult communities and change negative attitudes whereas IHA tended to think that perseverance over time, and familiarity via Befriending Schemes were the answers to hostility in the community. However, a Befriending Scheme was never implemented.

The MIND and PBT residents did not seem to have been the focus of community hostility. They were living in the poorer north of Islington in Health Locality A which *Appendix 4.17* shows was home to the largest number of projects and facilities for people coming from Friern, in an area of mixed land use, where there were schemes for other vulnerable client groups, a high proportion of council, housing association and private rented accommodation, and which had a younger, transient population. However, these projects did not require planning permission so the public did not know about them. Also, the characteristics suggest a 'lack of community' so perhaps the public did not care.

This means, therefore, that there would not be a community with which ex-patients could become integrated.

As *Appendix 4.17* also shows, the majority of residential projects and other facilities for people with mental health problems were located in the north of Islington. This may reflect, not only the shortage of property in the borough (as discussed previously) but also 'affordable' property.

In the wealthier south which has a high proportion of owner-occupied accommodation and listed buildings, the opposition to the PRA project was initially so strong that it nearly had to be abandoned. This opposition was initiated and organised by a local practice of GPs and the main areas of concern raised were that there would be inadequate staff support and day care facilities for residents. However, MIND and PBT also reported problems with GPs, that is in getting them to take responsibility for their residents.

A resident of Cloudesley Road, who was found to be disturbed and unreasonable, and whom police said was a well-known trouble-maker, complained that one of the PRA project residents had been displaying unacceptable behaviour in the street and harassing and violently threatening him. PRA first considered returning him to Friern for the safety of this resident and to safeguard the overall position in the house, but eventually moved him to the Clerkenwell project.

The Clerkenwell project, also in the wealthier south of the borough, was an 'enigma'. It had been initiated by the local community as a result of a talk about Friern closure



given by two specialists in mental health from LBI SSD in January 1983 at the Finsbury Lunch Club - a group of welfare professionals from the statutory and voluntary sector who later formed a Steering Group for the project and involved local tenants associations. However, the residents of the project were later 'ostracised' by the community, that is some were still sympathetic but wanted nothing to do with them.

#### THE ABERDEEN ROAD RESIDENTS MEETING

On the evening of Thursday 8th December 1988, the researcher attended a meeting to discuss the change of use of the property in Aberdeen Road (owned by LBI) to a home for a group of elderly demented people from Friern. It was attended by staff from LBI's SS and Architect's Departments, IHA, and residents of eight properties in the area, including three of seven young people who would be 'homeless' if the proposal went ahead because they were 'short-life' tenants of Islington Community Housing.

The meeting had been called in response to a letter dated 20.10.88 from 14 residents of Kelross & Aberdeen Roads to LBI's Director of Social Services which outlined their reservations about the proposal: fear that the project would be changed in the future to house more disruptive patients; concern that the building was not appropriate for the care of elderly patients; and, fear that changes to the exterior may adversely affect the quality of neighbourhood environment.

At the meeting, in response to a request for a guarantee that the property would not be used to house younger more disruptive patients in the future, professionals replied that although they were unable to give a written guarantee, they could give a firm assurance because of the continuing need for this type of accommodation due to increasing life expectancy. Further, there would be a contract setting out how the property was to be used and IHA would have to approve any change of use.

Concerns were voiced about excessive noise levels, fire risk (especially in view of the recent fire at Friern), and access for fire engines and ambulances especially when Arsenal Football Team play at home. Residents were told that these ex-patients would probably make less noise than an ordinary family because of their physical frailty, the fire regulations set out by the Fire Brigade and IHA guidelines had been followed, and they are not likely to need fire and ambulance services any more than other elderly people in the area and some medical matters will be dealt with on the premises. Also, access is a problem for the whole community on match days.

Many concerns were raised about patients or rather 'axe-wielding mad people' with the potential 'to rape' escaping and threatening the safety of people in the neighbourhood, especially children. Residents were continually assured that because of the physical frailty of these ex-patients, most would never leave the house, they would certainly never be able to leave unattended and there was 24 hour staffing.

Despite this, some residents were still determined to classify these ex-patients as 'mad' rather than 'elderly', because psychiatrists 'are not always right'. When these residents were informed that these ex-patients had not been mentally ill when young, that their illness had been caused by brain failure as part of the ageing process, they still believed that the house would be known as the 'madhouse' and that children would mock the patients when they were sitting on the balcony which was not fair to the patients who probably did not want to be with 'normal' people. They were then assured by professionals that there would always be staff around to protect patients from abuses and also that research shows that elderly people benefit from living in a homely environment in the community.

Nevertheless, many residents did not feel the house in Aberdeen Road was the right site for this purpose, the garden was too small - there were bigger properties off the Holloway Road and Archway. Also, changes to the exterior, especially wheelchair access may adversely affect the look of the street. In response, they were told that there would be plenty of room for the patients, they would have their own bedrooms and they were not likely to want to all sit in the garden at the same time. Also, Architect's plans had been drawn up to 'fit in' with other houses in the area and research had shown that having schemes such as these in an area only affects property values for a short time, if at all.

Some residents still felt that it would be better to keep these patients at Friern and spend money on making the

hospital a nicer place. When they were informed that Friern was going to close in 1993 and it was policy to move patients back to the community, they said that Friern was only closing so the land could be sold to make a profit and tax-payers should not have to pay for this. They were told that a part of the Friern site would be used by Haringey and although the rest would be sold off, money which was spent on patients in Friern would now be used in the community.

One resident who had consistently and vehemently been opposed to the siting of the project in Aberdeen Road then asked 'why is all this being done for the mentally ill, what about all the people sleeping in cardboard boxes at Charing Cross, men who fought in the war?' He was told that it was Government policy to close the large mental hospitals and move people to the community.

The majority of other residents were only concerned with the next stage, 'will it definitely go through?'. They were informed that if the proposal was approved by the Planning Committee in March, work would begin immediately and neighbours would be kept informed of progress. Also, all residents would be told when the project would come before the Planning Committee.

The researcher noted that there seemed to be class differences in the way residents expressed themselves - working class residents had no hesitation in making emotive and derogatory remarks whereas middle class residents voiced their anxieties in a more indirect way.

Further, the woman living next door to the proposed project had no objections as long as she was kept informed

of building developments. Because she was the person who would be most directly affected, the sympathy she expressed for the elderly demented patients seemed to shock most of the other residents out of being totally opposed to the proposal and hostile to the patients and professionals, and into focussing on more practical considerations and voicing objections with the welfare of the patients appearing to be their main concern.

At the Planning Committee Meeting on 14th March 1989, Friern Hospital was not mentioned and the prospective residents were described as frail, disabled, and elderly in need of care. Objections to the proposed project were made on the grounds of: difficult access for ambulances; problem of night-time parking; fire hazard; and, that the ramp for wheelchair access would be out of context with the area. After these objections had been answered by an LBI Architect and Councillors, the Chairperson of the Committee said:

*"I have been to a number of meetings on this, I have listened to arguments and objections to this scheme. On the question of the ramp, it is a run-down squatted council property. I don't think a ramp will draw more attention. On parking, it is for general housing use, quite elderly people. On the question of fire regulations, they have been adequately dealt with. On strict planning terms I don't think we can do other than pass permission for this."*

The researcher, therefore, photographed the property in Aberdeen Road in April 1989 before conversion began and 15 months later when the external work was complete. The photographs of the property pre and post conversion appear in *Appendix 8.8* and show that the negative concerns raised about the 'look' of the property proved to be unjustified.

## CONCLUSIONS

The sensitivity shown by many professionals to the rights of patients in the selection process seemed to the researcher to be rather superficial in view of the fact that patients did not 'have a say' in whether or not Friern should close. Patients also had little or no choice in complying with the closure programme, for example, in being assessed, moving to other wards because they were being considered for a particular project, making room for other patients being considered for particular projects on wards designated as project wards, or to effect ward closures, taking part in preparatory work for projects, and their final destination in the community.

Although professionals were generally sceptical of the ability of patients to choose where they wanted to move to in the community, their scepticism was never really tested. The first five residential projects had been 'decided upon' in terms of the type of accommodation and level of support by the managing agents before the assessment of patients had been completed, so they were not based on an assessment of patients' needs. Consequently, patients were selected for their ability to fit the projects, rather than designing projects to fulfil the requirements of patients. Long-term vacancies in some projects showed that they did not satisfy the needs of many patients.

Ward presentations were a way of offering patients some choice about their destination in the community. However, the ward presentations for the first three projects to be managed by the voluntary sector were really just

'recruitment exercises', since patients were not given information about the three projects at the same time, thus offering an element of choice. Therefore, the only real choice that patients had was a negative one - refusing to move.

Although the Ward Presentations in 1989 offered information on a range of projects 'in the pipeline', patients could not actually choose to move to a particular project, they had to be selected, and selection was based on their suitability to the project - the project was not adapted to suit their needs. For example, the older physically frail patients showing an interest in the Clerkenwell project at the Ward Presentations could not move there if they required wheelchair access and nursing care. Also, the Project Group had already short-listed mainly younger male patients.

Further evidence of patients' lack of choice comes from the failure to provide an all male Greek-Cypriot project and an all-female house. Patients' lack of choice could also be seen at the Project Group meetings, in that they were not represented, and very little priority was given to their opinions about moving to a particular project.

If all patients had been assessed before a decision on the type of projects to be offered in the community had been made and patients had a range of projects from which to choose, perhaps some of the anxieties patients had about leaving the hospital, which proved to be an impediment to preparing them for the community or resulted in them refusing to move may have been allayed. Also, Guardianship

should have been an option for patients whose families proved particularly problematic with regard to moving them to projects in the community.

If it had not been for the availability of properties owned by the Housing Corporation via Housing Associations and managed firstly by the voluntary organisations, and later by the statutory sector, the shortage of property in Islington would have been a serious stumbling block to the implementation of the closure programme.

The disagreements and uneasy relationships between statutory professionals and between statutory professionals and workers from the voluntary organisations seemed to reflect differences in their philosophy on the care and treatment of people with mental health problems, their experience or professional perspective, and location of operation - hospital, community, or both. Although the concerns raised by IHA about the selection of patients and the management of projects reflected a genuine concern for prospective residents for whose care, in hospital, they had had almost total responsibility, they also showed a desire by IHA to retain its authority in the community. The voluntary organisations, in particular, were not willing to allow IHA to assume this authority given that the projects they were offering were financially attractive to IHA.

Many of the disagreements and differences between the agencies and professionals involved in Islington's closure programme appeared to come from not adhering to the criteria for successful rehabilitation systems described by



Birchwood et al (1988)<sup>1</sup>. Therefore, many of them could have been avoided or resolved, if there had been a clear directive from NETRHA, more clarity in areas of operation and responsibility, selection criteria, and firmer policies on issues which were likely to cause disputes, for example medication, before the closure programme began.

Although all patients who moved to projects in Islington had a better quality of living environment, sometimes almost luxurious, when compared with Friern Hospital, there was no equality in their care. Due to the differences between project managers on, for example, type of accommodation being provided, level of support, and policy on medication, patients had very different experiences of moving to the community. This diversity in the destination of ex-patients in the community was also found by Jones (1985)<sup>2</sup> and Goldie (1988)<sup>3</sup>.

There was inequality in care between projects but also within one particular project - Adult Care. There were many problems with this project. Many of the people in Adult Care were living in the Friern area, some with ex-Friern nurses, and some also had social workers in the Friern SWT. This meant that there were difficulties in terms of day care places, building and maintaining community links, and breaking ties with the hospital.

There was also the danger that some adult care placements would be run like small businesses, that carers would not provide what they were expected to provide, and that ex-patients would not complain about their care at Reviews, in the presence of their carer. The exclusion of

psychiatrists at Adult Care Reviews may have been an omission in the light of the experience of one patient living in Adult Care who had seriously deteriorated, and in the absence of other formal monitoring procedures.

IHA had been generally 'weak' on formal monitoring arrangements. Apart from the above ex-patient in Adult Care, the negative effect of IHA's inability to implement a formal monitoring system was seen in the resident who was evicted from the MIND project for hostility to other residents and neighbours, the resident who was moved from the PRA project because of community hostility and who later disappeared from the Clerkenwell project, and the resident who was removed from the Clerkenwell project by his family. In the absence of a Case Coordinator, these ex-patients had all 'slipped through the net'.

Centre staff morale, the programme within centres, and the relationship between the centres and the community are interlinked and all affect the quality of services that are being offered to people suffering from mental health problems. Day Care is very important to users of mental health services, especially those also suffering from poverty, poor physical health, and isolation because it represents their main contact with people on a day-to-day basis. However, staff cuts in the LBI's Centres had, effectively, negated the new posts at a time when there was an even greater demand for activities which would enable ex-Friern long-stay patients to become integrated into the community because of a delay in some plans and the cancellation of others due to lack of revenue.

This meant that provisions for day care and employment for people leaving Friern were well behind those made for 'accommodating' them in the community. Therefore, people in Islington's Friern closure programme were not 'above' other people in Islington with mental health problems with regard to opportunities for day and work activities, as the Director of Social Services had suggested.

The lack of opportunity for day and work activities would explain why so many ex-patients returned to Friern to attend the South Workshop and visit friends, which must have been an impediment to them becoming settled into and accepted by a community where the outward appearance and other effects of long-term mental illness, treatment, and institutionalisation would surely make them more vulnerable than people with mental health problems in Islington who had not been 'shut away' from the community for years.

The lack of opportunity to engage in paid work in the community, and the small amount that could be earned without affecting entitlement to benefits, meant that ex-patients had very little money to spend on 'entertainments' in the community. Although they received slightly more spending money in the community than they had in Friern, it did not 'go as far' since Friern had been able to provide subsidised social activities on a regular basis by virtue of its large population. People living in Adult Care, who were not made 'part of the family' may have been more disadvantaged with regard to social activities than those in Group Homes since project workers did try to organise some events for residents.

Since ex-patients were generally too poor to join in mainstream community activities and, in the absence of a Befriending Scheme, regular social activities at Day Centres, as well as the apparent inappropriateness of the IMHF, ex-patients had little opportunity to engage in 'leisure' pursuits which would aid their integration in the community.

The problem of inadequate day care facilities, lack of opportunities for work and the resultant negative effect on finances and social activities was also identified by Goldie (1988)<sup>3</sup>, Birch (1983)<sup>4</sup>, Kay & Legg (1986)<sup>5</sup>, McLean (1987)<sup>6</sup>, and Rayner & Quarry (1986)<sup>7</sup>.

There was some evidence of Dear & Taylor's (1982)<sup>8</sup> 'accepting' communities around the PBT and MIND projects in the north of the borough. However, it was difficult to clearly identify 'rejecting' communities. Nevertheless, the opposition of GPs to PRA's project in the south of the borough seemed particularly serious - if they will not accept long-stay patients moving into their locality then other people in the community can hardly be expected to show a positive attitude.

Further, the granting of planning permission is no guarantee that local opposition has been quashed as seen in the PRA experience. It seemed that the early opposition to the project had left its mark, in that PRA gave priority to community concerns over the rights of their resident by moving him.

The change in attitude to the Clerkenwell residents may have been because the goodwill of local residents was lost

in the long time period between planning the project and actually opening, and it did not house the residents they had been expecting - they were younger, all men, and not all from the Clerkenwell area.

At the Aberdeen Road residents meeting, there was a tendency to see mentally ill people in a negative and stereotyped way which suggested they had less value as human beings. Even when it was explained that they were elderly, physically frail people, irrational fears remained. There was also considerable concern about how 'obvious' the project would be due to an underlying anxiety about falling property values in this area with high property values and a large number of properties which had recently been purchased by council tenants. However, the photographs of the property before and after the conversion show that the project was certainly in keeping with other properties in the area and in a vastly improved condition.

Despite the class difference between the Aberdeen Road residents, they shared the same concerns - fear of mentally ill people and falling property prices. This leads one to question what the outcome would have been if the woman living next door to the Aberdeen Road project had not been able to 'turn the meeting round', and whether she would have also been sympathetic to the needs of younger mentally ill people.

This elderly demented group would be cared for in the community, but younger people would be striving to become part of the community. In view of the reaction of Aberdeen Road residents, this community seemed unsuitable for hosting

other projects. However, an Intensive Rehabilitation Unit was later opened only one street away, an example of providers being unable to take account of community attitudes due to the shortage of property in Islington. The fact that seven young people would be made homeless by this project for seven elderly mentally ill people highlighted the scarcity and competition for housing in Islington.

All the Islington long-stay patients were provided for in the community by the closure date but this was in terms of numbers rather than allocating people to places considered appropriate for their needs.

The re-admission of Friern ex-long-stay patients even after two or three years of living in a project showed that some people in the closure programme would have a continuing need for hospital care. However, given the pressure on the Whittington Psychiatric Wing while Friern was still open, it would be unable to cope with the demand for admission from all those requiring hospital care once Friern finally closed. Further, the closure programme was limited in that it only really provided for long-stay patients and not all those requiring hospital care - 'revolving-door' patients and those just embarking on a career of 'mental illness',

#### RECOMMENDATIONS

All agencies, statutory and voluntary, including nursing staff should have been involved in the planning of the closure programme before residential projects were offered to patients, setting-up appropriate systems, determining policies on eg. medication, so that patients had equality of

care in the community, and staff should have been given adequate time and opportunity to retrain for projects in the community.

If patients assessments, re-assessments, and other records had been computerised and updated by people considering them for projects by a person appointed to be responsible for this work it would have lessened the workload of professionals who had been expected to undertake considerable administrative work in addition to their other closure work.

Patients should have been assessed and consulted before residential projects were planned, nursing staff should have had an early and firm commitment to employment in the community and moved with some patients in their care, work schemes should have been operational early in the closure programme thus making patients more enthusiastic about the move, and ward presentations should have commenced early in the closure programme thus offering patients some element of 'choice' with regard to their destination in the community. Central Services should not have been closed down until everyone was out of hospital.

Areas of operation and responsibility for all workers in the closure programme should have been clearly defined. There should have been a OT on the TT. The TT should have been appointed at the beginning of the closure programme to work on problems of social behaviour and negative attitudes to leaving hospital, before patients were considered for projects. The CMHRT should have been appointed earlier, given access to patient assessments and patients in hospital

in order to plan their day care. An Assistant UGM at Friern should have been appointed at the beginning of the closure programme to alleviate 'management' problems. A Case Coordination system should have been implemented at the beginning of the closure programme.

There is a need for programmes to educate local people about the problems and needs of people with mental health problems, and the affect of siting facilities for them in the community, so that real concerns can be separated from irrational fears before they are consulted about having a project in their area. This is particularly necessary with regard to projects for younger mentally ill people leaving hospital as a result of closure.

Residents meetings for future projects could benefit from distributing: information on closure policy; profiles of patients who may move there; examples of other schemes and research on their affect on property values; the draft operational policy and memorandum of agreement; a proposed timetable for building work; as well as architect's plans.



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## C H A P T E R 9

### THE FINDINGS OF THE PILOT STUDY

#### INTRODUCTION

This chapter is concerned with the findings of the Pilot Study, which was discussed in Chapter 4 (p112-120) and *Appendix 4.4*.

It begins with the experience of the two Friern ex-long-stay patients who were interviewed and to whom the researcher gave the fictional names of Douglas and James. All the material in this section is derived from the interviews with Douglas and James, and their keyworkers. It is presented under a number of headings which largely follow the order of subjects in the Draft Interview Schedule for Ex-Long-Stay Patients. However, it begins with 'The Hospital' since both men elected to begin with this subject. Some of the responses of Douglas and James are given 'in their own words', and these appear in bold type between inverted commas.

The chapter ends with a summary of the researcher's conclusions with regard to the project and the people in the Pilot Study by referring to the information given in Chapter 4, *Appendix 4.4* and the experience of Douglas and James. She also notes the significance of the Pilot Study in terms of the methodological approach and the findings.

## THE EXPERIENCE OF DOUGLAS AND JAMES

### The Hospital

#### DOUGLAS

"Life was not good in Friern. I was there for two or three years."

"Staff were not too good. I spoke to the Charge Nurse when I had a problem. I went to the North and South Workshops five days a week. I didn't have any friends."

"I felt happy when I was told I was going to leave. I've not been back to Friern since I left."

According to his keyworker, Douglas had first been admitted to Friern at age 16. He was discharged, then readmitted at age 20 when he was diagnosed as suffering from schizophrenia. Over the years, he had been forgotten in hospital. He became very quiet, withdrawn, unable to do much for himself, and was not used to being talked to. The schizophrenia had burnt itself out, but he then suffered from dementia. He was very anxious about leaving the hospital.

#### JAMES

"It wasn't very good in the hospital, terrible sometimes",

"Staff were all right. I went to the South Workshop five days a week. I liked the Oxford Club. I had some special friends. Some of them are still there. I wouldn't want to live with them now."

"I was worried when I was told the hospital was going to close. I didn't want to leave. I felt terrible about leaving."

According to his keyworker, James was first admitted to hospital when he had a breakdown at age 18. He was discharged, then readmitted at 22, and diagnosed as schizophrenic. He had had no active rehabilitation in

hospital. James seemed to experience a sense of loss on leaving the hospital.

### Life Pre-Hospital

DOUGLAS

"I lived in Cork, that was a beautiful place, and I lived in New Southgate on my own".

JAMES

"Can't remember where I lived or who I lived with. I think I worked in a garage."

His keyworker said he left school at 15 and worked for a time.

### Leaving the Hospital

DOUGLAS

According to his keyworker, project staff visited Douglas in hospital, on a daily basis and worked with him on self-care and cooking, encouraging him to do things for himself. He then visited the house from 10.00 am to 3.00 pm every day, returning to the hospital at night, to get him used to the house.

JAMES

"I had seen the house before but I hadn't come in. They just packed my case, and put me on a bus."

According to his keyworker, project staff had gone to the hospital to work with James on a daily basis on self-care and catering. He had come to stay at the house for weekends but was indecisive about moving, so hospital staff packed his things and put him on the bus. He felt scared and threatened by the move. He felt robbed of open spaces, security, and acceptance.

### Living in the Group Home

Both Douglas and James said they did shopping, cooking, cleaning, laundry, and gardening with 'others' in the house.

#### DOUGLAS

"I like nothing about the house. I don't like my room, it is too big."

According to his keyworker, Douglas was very willing to do domestic chores and did a lot of housework. He probably said he did not like the house because he was used to the long corridors and big grounds in the hospital but also to sleeping in close proximity to other people on the ward. The situation in the house was the reverse of this. He had become much more alert, and was dressing better since living in the project. If it were not for his dementia he could probably have moved on to a less-supported environment.

#### JAMES

"I like getting cigarettes from the workers. I don't like the lack of space, it makes me feel more ill. I need more space."

During the researcher's visits to the house, James spent nearly all his time sweeping the kitchen floor with a ward-sized broom. According to his keyworker, James needed motivating to carry out his domestic chores although he was motivated to go to the shop to buy cigarettes and to visit Friern to find familiar faces and to avoid things in the house. He was very withdrawn when he moved in, but he had become more animated and sociable.

Community Life

Neither Douglas or James mentioned having any contact with the neighbours.

DOUGLAS

"The area is not bad. I go to the Railway Pub once a week. It is friendly. I use local shops and a cafe and go to Church elsewhere."

JAMES

"The area is all right. I use the local shops, I go to the Off Licence for cigarettes. I'm frightened when I go out because there seem to be a lot of dangerous people out there. They may not be dangerous but they look it. I like going to the pub but the people there look very dangerous, and the youngsters that hang about the streets."

Daily Life

DOUGLAS

"I have no work. I don't go to Centres. I would go to Centres in the evening if they were open. I go out walking or stay in the house. I watch TV sometimes. I go to bed early. I like making things with the workers."

According to his keyworker, Douglas enjoyed the artistic activities in the house, and going on outings on Sunday in the van.

JAMES

"I do no work, I used to in Friern. I've been to Crossfields once for a cup of tea and we talked. I stopped going because I don't like travelling and it was two miles away. Every week is different cause we change jobs. I watch TV in the evenings. I only go to hospital for a day out. I like smoking cigarettes."

The keyworker for James could not understand why James had been unwilling to travel to the Crossfields Centre, since the journey to Friern was much longer and more arduous, and he was always keen to embark on this.

Both keyworkers felt that now that Douglas and James

had 'settled in', attending some sort of Centre was a priority for both of them, although they felt that it would be difficult to motivate them to attend Day Centres on a regular basis, without the financial incentive that there had been at Friern for going to the Workshops. A work project would be the ideal solution, but they did not know if anything suitable was available.

### Finances

DOUGLAS

"I manage for money. I spend most on cigarettes."

According to his keyworker, Douglas was not very good with money and needed help with managing his finances.

JAMES

"I had no money for five weeks. The Head sorted it out. I spend most money on cigarettes."

According to his keyworker, James had quite a bit of savings when he moved into the project, but he had been spending it very quickly.

### Medication

DOUGLAS

"I have the same. I have been feeling all right."

According to his keyworker, Douglas did not take any medication.

JAMES

"I had the same medication. I told them it was making me feel ill and I stopped taking it."

According to his keyworker, James had been taking the same medication as he did in hospital. He was self-

medicating daily when he first moved into the house but then staff began administering his medication because, for a time, he did not take it, and had a relapse.

### Contacts

#### DOUGLAS

"I have no family or friends. I only see the workers in the house. They help with problems."

According to his keyworker, Douglas had a niece in London and family in Ireland but he had had no contact with them, although they did send him cards and money. He had a GP and saw a Friern Consultant.

#### JAMES

"A lady comes to visit. I call her my Mum but she can't be cause I knew her in Friern. She hasn't been for a few weeks. I have a brother in Ireland. He visits every one or two years."

"I have a CPN and a GP. I don't see them very often. The last time was when the tablets changed. I like the Doctor. I go to the Royal Free for drugs and to Friern to visit. My worker here helps when I have a problem. The last time I spoke to him was cause I had no money."

According to his keyworker, James was not close to his family and he questioned their existence. His mother visited him every few weeks and his brother telephoned. He saw a psychiatrist once a week.

### Life in the Community v. Life in the Hospital

#### DOUGLAS

"My life is worse now, I wanted to stay in the hospital".

According to his keyworker, Douglas seemed to like living in the group home, probably because of the huge input of the staff, and he did not want to go back to hospital.



## JAMES

"I've not been feeling very good since leaving the hospital. I get a pain in the morning. My problem is being so far away from the hospital. I visit the hospital every three weeks. I like the hospital. I would like to go back."

According to his keyworker, James repeatedly said that he wanted to go back to hospital, however, once when he was sent back to the hospital after a fight in the house with another resident (there had been trouble between them for years in hospital), he told hospital staff that he wanted to go home to Hilldrop Road.

## CONCLUSIONS

### Onset of Illness

Both Douglas and James had first been admitted to hospital with mental health problems in their teens, and had been diagnosed as schizophrenic by their early twenties. As outlined in Chapter 5 (p160), the highest rate for the onset of schizophrenia in men is between the age of 15 and 24. The researcher, therefore, concluded that Douglas and James' experience of the onset of schizophrenia was 'typical'.

### Life in Hospital

The researcher found that little was known, or could be remembered by Douglas and James themselves, about their life pre-hospital. Therefore, Friern was the only world that they had known for a very long time, and she concluded that it was a world in which they had largely been forgotten. This would explain why they were so quiet and withdrawn when they first moved into the project and why they were so surprised that the researcher wanted to talk to

them about their experience. Also, if Douglas was a burnt-out schizophrenic who was not on any medication and who had made such good progress in the project that he could have moved on to less-supported accommodation if it had not been for his dementia, why, if he had not been forgotten, had he been in Friern Hospital for 37 years?

She further concluded that it was because Douglas and James had lived in Friern Hospital for such a long time that they chose to begin the interview with the section on the hospital - it was an old and familiar environment so questions about it were unlikely to be so threatening as those on the community, which was a new and relatively unknown environment. This would also explain why James 'felt terrible about leaving' the hospital.

#### Underoccupation of the Project

There were only four residents living in the project, designed for nine people, eight months after the operational date. One placement had permanently broken-down, and three people had only recently been selected for the project. The researcher concluded that the underoccupation of the project appeared to indicate a failure in the planning process with regard to anticipating the operational date of the project, and selecting and preparing patients for the move, to coincide with this date.

This failure was likely to have had negative financial and human consequences: the high cost of running hospital and community services in parallel; and, relative isolation for those who had moved into the project - they had been

accustomed to living side-by-side with a large number of other people in the hospital and, at a time when they were very vulnerable because they had just recently left the hospital, they were living with very few others.

#### Employment of Agency Staff

The researcher concluded that the high proportion of Agency staff working in the project also seemed to reflect a failure in the planning process - inadequate time had been allocated to recruit permanent staff before the project opened. Again, this failure had financial and human consequences. Agency staff cost more to employ than permanent staff and, because of the flexible and insecure nature of their employment, they may not feel or be expected to show the same level of commitment to the residents as permanent staff, or be able to offer them the consistency they require to make a successful transition from the hospital to the community.

#### Hospital v. Community - The Environment

Friern Hospital was a huge building set in extensive grounds whereas the group home and garden, although a generous size by Inner London standards, must have seemed very small to the residents, by comparison. In hospital, Douglas and James had slept in very close proximity to many other patients on the ward whereas in the underoccupied group home, they were sleeping alone in a double room. The researcher concluded, therefore, that the hospital and community environments were completely different and, due to the length of time they had lived in the hospital

environment, it must have been very difficult for them to adapt to their new living arrangements in the community. This would explain why Douglas complained that his room was 'too big' and James complained about a 'lack of space'. Also, James had adopted the ritual of sweeping the kitchen floor with a ward-sized broom.

The researcher found Friern Hospital to be gloomy, dilapidated, and with few home comforts. The group home was bright, homely, and luxurious, by comparison. However, stubbing-out cigarettes on the wards or long corridors of the hospital was not a problem, whereas in the group home, the same practice ruined carpets and constituted a fire risk. She, therefore, concluded that some behaviour which was common-place in the hospital, may be unacceptable in the community, and ex-patients would have to learn or re-learn appropriate responses. Given their long-term institutionalisation, this would be not be easy.

### The Keyworkers

The keyworker for Douglas was a permanent member of staff who had been working in the project since it became operational, whereas the keyworker for James was employed by an Agency and had only been his keyworker for six weeks.

The researcher found that both keyworkers seemed to rely on the medical model of mental illness when describing the behaviour of their residents, and she concluded that this may be due to the influence of the psychiatrist who attended the weekly staff meetings. Also, both keyworkers

tended to be more optimistic about the life of their residents in the community than the residents themselves.

She found that the keyworker for Douglas appeared to have a good understanding of his behaviour and to be able to help him with his problems. The keyworker for James, however, seemed to consider all the thoughts, feelings, and behaviour that he, the keyworker, did not understand, to be irrational or symptoms of schizophrenia. For example, he did not understand why James refused to travel to a Day Centre, but would make the more arduous journey to Friern Hospital, and also why he denied the existence of his family. The researcher thought that these 'actions' made sense from the perspective of James himself. The long journey to Friern was rewarded by familiar faces and surroundings whereas a trip to the Day Centre was like going 'into the unknown'. The confusion surrounding the woman who used to visit him, that he thought was his mother, but could not be his mother because she had visited him in Friern, may have come from his belief that a mother would not leave a son in Friern for 29 years. She, therefore, concluded that it would be difficult for the keyworker for James to help him with his problems because of his lack of understanding of the meanings James attached to particular events and people, which further illustrates the problem of employing Agency staff.

### Work and Leisure

The researcher concluded that Douglas and James led a very sheltered and boring existence in the community alleviated

only by a daily trip to the local shops, an occasional visit to the pub, and a weekend outing for Douglas and a visit to Friern for James now and again. This was in sharp contrast to their life in Friern Hospital where both men had worked five days a week in the Workshop for a small payment. Also, a 'social life' was more expensive in the community for several reasons. Cafes were not subsidised as they had been at Friern and outings and events for small groups of residents cost more than organising them on a large-scale which had been the practice in the hospital, due to its huge in-patient population. Further, it was not as easy to 'cadge' cigarettes as it had been in hospital which meant that most of Douglas and James' money was spent on this 'pastime'. The high cost of paying for entertainment in the community and the lack of any paid work would explain why James was getting through his savings so quickly.

She, therefore, concluded that there was an urgent need for the residents to take up some sort of paid employment in the community, not only to add structure and meaning to their day but also to alleviate their financial hardship. Both the keyworkers had admitted that a Work Scheme was the most desirable day-time activity for both Douglas and James, but they did not know of any that was available. This shows that it is not enough to provide only residential accommodation in the community for long-stay patients. Work-related activities which provide them with the opportunity to earn some extra money must also be created so that they do not feel that they have 'lost out' by the move to the community.

From some of their replies, the researcher concluded that Douglas and James may, in fact, have felt that they had 'lost out', that the reality of life in the community did not match their expectations. For example, Douglas initially said 'I felt happy when I was told I was going to leave' but later 'my life is worse now, I wanted to stay in hospital'. Also, James initially said 'it wasn't good in hospital, terrible sometimes' but later 'I like the hospital, I would like to go back'.

#### Contacts in the Community

The residents of the group home may, as the project workers had pointed out, go about the area unnoticed. However, the researcher noted that this unobtrusiveness was not reciprocal since James viewed the people in the pub and on the street as 'dangerous'. The stress caused by this fear may explain why the medication he had taken in the hospital appeared to be ineffective in the community. She, therefore, concluded that it was very important to monitor the effects of medication when long-stay patients first moved from the familiar and sheltered hospital environment to the alien and potentially threatening environment called 'the community'.

The researcher found that Douglas and James had scant contact with their families, no contact with their immediate neighbours and, although they spoke about places in the wider community, they did not mention specific people. They also had little contact with professionals in the community, which was in contrast to what she expected to find from her

interviews with Islington ex-long-stay patients, who should have input from a wide range of professionals. She concluded that, due to a lack of personal and professional contacts, Douglas and James relied heavily on project workers for a social life and to help them with their problems. Dependency on these workers may make them disinclined to move outwards from the group home to broaden their social network, and also make them very vulnerable when these workers, especially keyworkers, left the project. This was of particular concern given the high proportion of Agency Staff employed in the group home.

The researcher found no evidence of the reported unhealthy relationship between project staff and the GP who had been forced to take responsibility for the residents, in the accounts of Douglas and James. However, this was a very important issue because closing a hospital such as Friern does not simply mean moving long-stay patients into residential accommodation in the community. It also entails providing all the other services that the hospital offered, and this requires the cooperation of community-based professionals. If GPs will not accept long-stay patients moving into their locality, then other people in the community can hardly be expected to show a positive attitude to the strangers in their midst.

#### The Significance of the Pilot Study

The significance of the Pilot Study from a methodological perspective was discussed in Chapter 4 (p119-120). However, the researcher also concluded that the personal accounts of



Douglas and James, the information provided or opinions given by their keyworkers and her own experience of conducting the interviews gave a very graphic insight into the experience of these ex-long-stay patients of life in hospital, moving to the community and living in the community, thus further justifying the adoption of a qualitative approach.

Although it was not possible to generalise from the findings of the Pilot Study due to the small number interviewed, the findings were significant for several reasons.

Firstly, the Pilot Study was concerned with a group home which was part of Hampstead's Friern closure programme, and from the researcher's growing knowledge of Islington's closure programme, the findings suggested differences between the districts which raised the question of whether long-stay patients of the same hospital had 'equality' of care in the community. Secondly, however, the ex-long-stay patients interviewed in the Pilot Study may have much in common with those she would be interviewing in Islington because they were all ex-long-stay patients of the same hospital and, as such, may have similar experiences of leaving and adapting to life in the community.

Thirdly, the keyworkers interviewed in the Pilot Study may have much in common with their counterparts in Islington because they are essentially dealing with the same group of patients. Fourthly, the Pilot Study emphasised the importance of issues the researcher had foreseen but also introduced issues which she had not anticipated.

The researcher concluded that the full significance of the Pilot Study could only be determined following the presentation of the findings with regard to the experiences of ex-long-stay patients in Islington which are the subject of Chapter 10.

## CHAPTER 10

### ISLINGTON EX-LONG-STAY PATIENTS

#### INTRODUCTION

This chapter is concerned with the experiences of the ten people who had been long-stay patients on the Islington wards of Friern Hospital, and who were living in a project in the community at the time of the interview.

Their experiences are presented individually, in the form of an historical narrative, with the account moving through the life of the person interviewed. It begins with their life before they were admitted to Friern, followed by life in hospital, moving on to various aspects of life in the community, then looking back to the hospital, and finally forward into the future.

All the material in these narratives is derived from the interviews with the ex-long-stay patients themselves, their workers/carers/contacts, and any 'profiles' presented at Project Group meetings. Much of the material is presented in the ex-long-stay patients' own words and this is indicated by bold type and inverted commas. When subjects were introduced or comments made, which appeared to be significant, by carers/workers/contacts, this is acknowledged by presenting what they had to say in italics. Information which was derived from Project Group meetings is prefaced by an asterisk.

To protect the anonymity of the ex-long-stay patients interviewed and to assure the confidentiality of their replies, they have all been given fictional names - men and women have been given names beginning with the letters A and

B, respectively. None of these names in any way resemble their real names. Further, the residential projects in which they were living are not specifically named, and professionals, family members and friends mentioned by the ex-long-stay patients have also been given fictional names. However, in order that the reader might distinguish between GPs and the Friern Consultant/Community Psychiatrist, the researcher would mention that Dr Robertson and Dr Baxter refer to the latter. The names of places, for example, Day Centres, churches and shopping ares have not been changed since the researcher did not think that the identity of the ex-long-stay patients could be deduced from these.

The accounts of the ex-long-stay patients are not presented in any particular order. At the end of each account, the researcher's observations on the ex-long-stay patient interviewed are given, followed by a discussion of the salient themes which emerged and her conclusions and recommendations. The chapter concludes with a summary of the material contained in the individual accounts and the researcher's final conclusions and recommendations.

### BERNADETTE

#### Background

Bernadette was 44 years old, a widow with two sons aged 14 and 16, who had been living in a project in the community for three years at the time of the interview. She had been in Friern for one year with a diagnosis of schizophrenia.

### Life Pre-Hospital

*Bernadette comes from a wealthy, professional, Anglo/Irish family. Her mother, who is a doctor, is very dominant. Her father is an artist. She attended public school, then went to Oxford University.*

Bernadette worked in an Art Gallery for a short time before getting married and becoming a wife and mother. She lived with her husband and sons in a council flat in Highbury, Islington. "When my husband became ill, I found it difficult to cope with the housework, children, and paying bills".

*Bernadette's mother offered to help financially but Bernadette refused because she resents her mother. Both sons were taken into care and Bernadette made scenes outside the Children's Home. Eventually, the younger son went to Foster Parents and the elder to Boarding School, paid for by Bernadette's mother.*

"I was taken into hospital because I was untidy and had no heating, but that was because I had had no social security benefits."

### Life in Hospital

"I was very unhappy in hospital. It was deadly boring and the building was very gloomy. I went to Rehabilitation Workshops, Cookery, and Discussion Groups. I didn't particularly like any of these things but they were something to do".

Bernadette did not have any special friends in hospital but thought the staff were "quite nice". If she had a

problem she did not speak to anybody about it - "you just keep things to yourself".

While Bernadette was in hospital, her husband died of cancer. Her mother instructed hospital staff not to tell Bernadette about this because she did not want her to attend the funeral in case she made a fuss, and upset her sons. Bernadette was very angry that she had not been told about her husband dying, and the funeral.

"I felt much cheerier when I was told the hospital was going to close, and overjoyed about leaving. It was like D-Day."

#### Preparing to Move

When a presentation was made about the project to Ward 5, Bernadette was very active about saying she wanted to move and was really interested in the project. She also said she would like to live with Oxbridge graduates. At that time, Bernadette had been in hospital for less than a year so there was a problem around her being defined as long-stay. Rehabilitation work on shopping, cooking, and budgeting had to be done to prepare Bernadette for the move to the community. She had become a vegetarian so she had to learn to cook food which would ensure she had a proper diet. She spent a lot of money on cigarettes, so she had to learn to control her money. She also had to learn to live in a shared environment. Bernadette was one of the first two movers to the project.

## IN THE COMMUNITY

### Initial Problems

Bernadette had significant problems paying for her accommodation and food. She did not receive DSS benefits for six months because she did not have a National Insurance number. The project managers made her a loan but could not afford to give her the whole amount that she was entitled to. When she first began to receive her money direct, she sometimes did not acknowledge that she received it. There was also a problem finding a GP for Bernadette, and in getting her to take responsibility for the shared environment, for example, she used to drop ash everywhere.

### Daily Life

Bernadette did her own shopping, cooking, washing-up, laundry, and cleaned her own room. On an average day, Bernadette got up fairly late and had a cup of tea and a cigarette in the kitchen.

"I meet my fiancée, he lives nearby, and we go for a drink, watch TV, have something to eat, and then have a rest. Sometimes I have supper at his place and in the evening we go to the pub or watch TV. I watch a fair amount of TV and read a bit. I don't do any sports but used to like tennis. I like doing things with my fiancée."

"I don't go to any Day Centres now. I used to go to the Links Club. It was pleasant but boring. The people were friendly but they just sat saying nothing. I stopped going because it was boring. I used to do voluntary work

for two pounds a day but stopped because it was cripplingly boring."

Bernadette had not been away for a holiday, or a weekend, since she had been living in the project. She did the same things at the weekend as she did during the week. Bernadette had never been to any meetings of the IMHF, and did not seem to want to be associated with people with mental health problems.

### Community Life

"I think the area around here is very pleasant, although it can be lonely, and when it's dark you have to be careful your bag isn't snatched. I don't see the neighbours very much so I havn't any opinions about them."

*Bernadette is called 'Princess' by the local children. They shout after her but she seems oblivious. She is rather 'Bohemian' and sometimes does strange things, for example, sitting on the ground while waiting for the bus.*

Bernadette shopped in Stroud Green Road, usually with her fiancée. They went to the World's End pub in Finsbury Park every day. She also went to St Mellitus Church in Tollington Park every day. *She was trying to become more involved with the church before she met her fiancée.*

"The thing that is missing around here is a cafe. I sometimes go to a cafe in Stroud Green Road."

### Finances

"I get forty-three pounds from the DSS for myself. It is a bit tight paying for accommodation and food and I am always scrimping."



### Professional Contacts

"I used to see my social worker every six months when I was settling in. I used to go to his place in Grosvenor Avenue. I havn't seen him for a long time. I can't remember his name. I only see a GP every six months when my prescription comes, it's a different one every time. I don't take any pills now, I just have an injection which is better. The CPN comes every three weeks to give me the injection. I've been feeling all right since I left Friern."

*Bernadette insists on having the injection in her arm but as she is very thin, it is a strain on her veins. She told her CPN that she wanted to reduce her medication. The CPN agreed but said Bernadette would have to consult the project psychiatrist. Bernadette did not bring this up with Dr Robertson when she next visited. She used to visit Bernadette monthly, but the visits petered out.*

"Two workers visit the house every day. I really miss Arthur who used to work here. He was such a nice person and he taught me how to cook. I don't have the same rapport with Simon. A very nice girl used to come from the Team, for tea or dinner, but she stopped coming, I don't know why."

### Social Network

"I spend most of my time with my fiancée. I also have friends who live nearby. We meet for a drink or to watch TV. I visit Maggie May in Shepherds Bush every three or four weeks. I also have friends who live in Clapham Common. I see them once a year. They don't come to visit me at the

house but we go for walks, to the cinema, for a meal, and once we went to Bath."

Bernadette's father and mother both live abroad. Her father writes to her, and her mother visits every three months. Bernadette and her mother hate each other but Bernadette gets material benefits from her mother's visits - she takes her out, spends money on her, and pays off her rent arrears. Bernadette visits her aunt who is a sculptor and goes with her to Gallery openings.

Bernadette told the project workers that she wanted to see her sons, but their social worker was not keen because it could have an unsettling effect, especially on the younger one. Eventually he agreed that Bernadette could meet the elder son, in his presence, and Bernadette's mother arranged the meeting. A project worker and some friends were also there, and it went well. After this meeting, Bernadette had the idea of getting a council flat so that they could live together. An accidental meeting with the younger son, but also arranged by Bernadette's mother, came to nothing.

Bernadette's elder son was expelled from Boarding School for graffiti and, while attending an Islington Sixth Form College, he was arrested. He gave the police Bernadette's telephone number. She went to see him, but soon after gave up the idea of them living together because it might mean trouble. He still seemed to want to be close to her, and visited her at the house, and telephoned. She did not return his calls. By this time she had met her fiancée.

Life in Hospital v. Life in the Community

"The thing I like about living here is that I am free to do what I like. The thing I do not like is that there is a degree of supervision. One is always conscious of it, and if you do something wrong you could be told to leave. You are worried that if, say, you play music loudly, you will be sent back to Friern. Another resident was sent back to Friern. He was not very ill and he did not want to be sent back. He came back again, I was pleased to see him."

"I am not going back to Friern. I didn't like the idea of being in hospital for no reason. I used to go back to visit a boyfriend but I stopped. I feel gloomy when I think about Friern now. My life has been marvellously different since I left the hospital."

"I would like to move on from here but I don't want to live on my own. The workers sort out your DSS here and that was the cause of my going to hospital in the first place."

*Bernadette would like to move on with her fiancée but he is divorced and does not seem to want to be tied down. He sees other women which could hurt Bernadette.*

Researcher's Observations

Bernadette was a very pleasant, friendly, hospitable, and articulate woman. She seemed to welcome the opportunity to 'have a chat' and to be disappointed when it was time for the researcher to leave. She said she had enjoyed the interview and was very grateful to receive the money for participating.

### Conclusions and Recommendations

Bernadette's illness seemed to have been precipitated by her inability to deal with economic difficulties and other problems resulting from her husband's illness, but she also seemed to have an unhealthy relationship with her mother which may have been a contributory factor.

The fact that Bernadette was not told about her husband's death appears to have been an infringement of her rights, and hospital staff may have agreed to this because of the prestige attached to her mother's profession. Bernadette, although very angry, does not appear to have confronted her mother or the hospital about this. She generally seemed to be a very complacent person, probably as a result of a lifetime of being dominated by her mother. For example, she expressed a desire to reduce her medication but did not talk to the community psychiatrist about this, and she did not question why a member of one of the Rehabilitation Teams stopped coming to visit her. The researcher would, therefore, recommend self-assertiveness classes for Bernadette.

It was fortunate for Bernadette that she was included in the hospital's closure programme since it is unlikely that she would have been able to cope on her own in the community without support. In her three years in the project, Bernadette appeared to have made good progress, probably because she was so keen to leave and had a good relationship with the project worker who prepared her for the move, and supported her for the first two years in the community. This shows the positive effect of having

permanent project staff who get to know people before they leave the hospital, and stay in post for a sufficient time to help them settle into the community.

There were, however, several problems with regard to Bernadette continuing to make progress in the community. With regard to her medication, at some point her wishes concerning her injections might have to be disregarded, for the sake of her physical well-being.

Bernadette had expressed a desire to move on to more independent living, but the association between her economic difficulties and being taken into hospital was so strong that she seemed to be afraid that if she lost the support of the project workers, history might repeat itself. The fact that she did have problems with the DSS when she first moved into the project was likely to have reinforced this fear. Also, although Bernadette appeared to be oblivious to any teasing she attracted in the community, this might not be the case if she was living independently in a rougher area.

Bernadette's dislike of the hospital seemed to be so strong that she was afraid of doing anything 'wrong' in the community that may cause her to be returned to hospital. This may explain why she broke off contact with her elder son - he involved her in his problems when he came to the attention of the police and she did not want to be associated with anything that may threaten her freedom.

Bernadette seemed to have a good social network of family and friends, to make good use of places in the wider community, and the financial support she received from her mother meant she only had to 'scrimp'. However, she did not

attend any organised day-time activities, probably because she did not want to be associated with people with mental health problems and because she had not found them stimulating. She did seem to want to be part of something, as seen in her preoccupation with the church before meeting her fiancée, and how she relied heavily on him to share, and bring structure to, her day. Since Bernadette's fiancée may not share her desire for a long-standing relationship, the researcher would, therefore, recommend channelling Bernadette towards mainstream community activities, perhaps of an artistic nature, to add more substance to her day, to broaden her horizon, and make her more independent.

## ALAN

### Background

Alan was 54 years old. He described himself as single and Irish. He had a history of mental health problems and had been in Friern continuously for two years with a diagnosis of schizophrenia prior to moving to a project in the community. He had been living in the project for 11 months at the time of the interview.

### Life Pre-Hospital

\*When Alan was married, he worked in a factory. After a breakdown in 1974, he went to live with his brother in a flat in Isledon Road, Finsbury Park which had housing support from PBT. He also worked in the Trust's workshop. He had frequent hospital admissions and in 1987 he was

admitted to the Whittington Psychiatric Unit because he had become catatonic and very ill and PBT could not longer support him. The following year, he was admitted to Friern Hospital.

### Life in Hospital

"When I look back now, life was terrible in the hospital. I liked the interviews and the music but we have a stereo here."

Alan used to go to the South Workshop and to the Cooking Group with two friends. "I had a few friends in hospital. Some of them moved here, some are still in hospital. I got on well with the hospital staff. If I had a problem I spoke to the Charge Nurse. I was surprised when I was told the hospital was going to close but I was glad to leave."

## IN THE COMMUNITY

### Domestic Life

Alan had been living in the project since it opened. His room was on the ground floor. "I like the house in general but not doing my washing. I cook and clean, the staff help, and I do my own washing. I don't do shopping or the garden because I have a bad leg."

*Alan was not prepared for the move properly in the hospital and this made the project workers' job harder when he came to the house. Alan does not refuse to do his domestic chores unless he is unwell, but he requires assistance and guidance with these practical things, and with his DSS.*

### Finances

"I havn't had any problems paying my rent and for food, or with the DSS but I don't get enough money. After I've paid for my rent and food, I only have eight pounds left and that goes on cigarettes. I could manage better if I had ten pounds a week more."

### Daily Life

Alan attended the Margery Street Work Centre every weekday morning from 9.00 am - 1.00 pm. "I make labels for cases. It is very nice there and better than the Workshop at Friern. I would have liked to have done carpentry at the Centre but it wasn't available and now I'm not able."

Alan also went to the Peel Centre for elderly people, one afternoon a week. On the other afternoons, he read books. "I read a lot, and watch TV. In the evening I do washing or watch TV." Alan did not like going out in the evening and at the weekend, he usually stayed around the house. "We went to a house in Devon for a week and that was very nice." Alan had not been to any meetings of the IMHF but had heard that "they are very nice".

### Community Life

"I think the area round the house is very nice. I like it because it's quiet. I don't have anything much to do with the neighbours but they come in and visit. They seem friendly. I once went to the pub next door and that was very nice."

"I joined the library and my keyworker delivers my books. I don't go to the park or to church because of my



bad leg. We went to the cinema once but were too late for the film so we went to an ice-cream parlour instead."

### Professional Contacts

Alan had a GP in Lloyd Square whom he saw now and again for a check-up. He saw a CPN at the Work Centre for his medication. "I have the same medication, an injection, as I had in hospital. I've been feeling better since living here." I see Dr Baxter every two or three months at her Clinic. I really like Dr Baxter. I don't have a social worker. I don't see the Transitional Team any more but they are coming to the barbecue. Jennifer from the Community Team visits me."

"The person I see most is my keyworker, John. If I have a problem, I speak to him and then I have no more worry. The last time I spoke to him was when I was depressed."

*Alan went through a bad period about six months after leaving hospital. He became withdrawn and confused and was not sleeping for two or three days. He was given additional medication, which he is still on, and the GP visited him.*

### Social Network

"I have friends here, they used to be in hospital. My brother has been to visit twice for tea and a chat."

*Alan's brother visits and writes to him.*

### Life in Hospital v. Life in the Community

"I havn't been back to Friern since I left and I wouldn't like to go back now. My life has been different here because I'm more responsible."

*Alan has become generally more outgoing and more sociable since living in the project.*

### Researcher's Observations

Alan was well turned-out and looked much happier than when the researcher had last seen him in hospital. He was a bit shy at the beginning of the interview but was quite talkative and friendly by the end. He said he had enjoyed the interview and was very pleased to receive his money.

### Conclusions and Recommendations

Alan had a long history of hospital admissions for mental health problems, latterly becoming more serious. Because of this and his age, it is unlikely that he would ever have left hospital if it had not been for the closure programme.

After living in the community for 11 months, Alan still required support with domestic chores and administrative matters, and to ensure that he did not become too withdrawn. However, he did seem to have made good progress probably because he had a positive attitude to leaving, he had benefited from intensive professional attention in a small group setting, and he had not had to be re-hospitalised even when he became very ill.

Alan seemed to have a good structure to his daily life, and the Workshop he attended in the community compared favourably with its hospital equivalent. Attending the

Centre for elderly people should give him the opportunity to broaden his social network with people who did not suffer from mental health problems. He seemed settled in the community and regarded his life in hospital as an experience he did not want to repeat. The only negative aspect of life in the community that Alan mentioned was lack of money.

However, Alan had scant contact with his family and nothing different to do at the weekends. Because of his bad leg, an ailment which would probably prevent him moving onto more independent living and making his ground floor room available for another disabled person, he could not make use of places in the community and this made him more socially isolated. The researcher would, therefore, recommend that Alan be matched with a Befriender with transport, who would visit regularly and sometimes take him out at weekends.

## ALBERT

### Background

Albert was 33 years old, single, and he had been living in a project in the community for 10 months at the time of the interview. He had previously been in Friern for two years with a diagnosis of schizophrenia.

### Life Pre-Hospital

\*Albert had had problems since he was 14, and had not been in employment very often. On the death of a parent, he had to leave the family home and live in a hostel. Two aunts kept an eye on him, but he became wayward. When his

remaining parent died, he lived with one of his aunts for a time, then moved to a Circle 33 flat in Holloway. By this time he was drinking heavily and, after being the victim of a knife attack and having problems with a girlfriend who was the mother of his baby daughter, he became isolated and unable to cope. He was 'signed-off' sick and received Invalidity Benefit before being admitted to Friern.

### Life in Hospital

\*In Friern, Albert was friendly and caring, and liked being part of a group. He quickly became entrenched in hospital life, gaining five stone in weight through sitting around. "People were really ill in hospital and that made me feel worse."

"I had a special friend in hospital. He moved to the project too but he couldn't settle and went back to the hospital. He won't be coming back here. I told him he would have to try and settle if he was going to get on."

"I got on well with hospital staff and if I had any problems I would tell the nurses. I used to go to the workshop. I really liked the discos in the hospital and there is nothing like that here."

"At first I felt sad when I was told the hospital was going to close, then I got used to it. I felt sad about leaving the hospital."

### Preparing for the Move

\*Albert turned down an informal Adult Care placement in the Friern area with an ex-nurse not long after a Ward Presentation on the project, to which he eventually moved,

had been made. His move to Ward 13, the ward designated for people being considered for the project, went smoothly. Originally Albert wanted to move to the Group Home because he wanted an older peer group, but the Project Group felt that he would be able to move to a Bedsit.

\*Preparatory work for moving him to the project centred on his daily living skills and involving him in group activities. He made good progress and remained keen on moving to the project, despite the long delay in its operational date. He did, however, express concern about the cost of the rent and the availability of day-time activities.

## IN THE COMMUNITY

### Moving In

\*Albert originally came from the area in which the project was situated.

An article describing the official opening of the project in a local newspaper, the Islington Gazette (20.9.90), was accompanied by a photograph of a smiling Albert, smartly dressed in white shirt and tie, ironing in the kitchen of his new Bedsit. He was described as 33 and a schizophrenic who had been in Friern for two years. Albert was reported to have said: "I'm looking forward to being independent - it's a great place here. I'm looking forward to doing my own shopping and having some friends round."

### Initial Problems

*Initially Albert found living in the Bedsit a big change and did not seem very settled. He was not accustomed to*

organising his own affairs, cooking or shopping, and he did not seem to have been well-prepared for the move. He was lonely and isolated in the Bedsit which made him mentally agitated. He heard voices, suffered from depression, and did not take his medication. Sometimes he locked himself in the Bedsit and slept all day. He had problems with budgeting when his depression led him to buy things to make him happy. Since he saw the hospital as a place where problems are solved, he talked about going back there.

#### Domestic Life

"I really like living here because it is my own place and I have space. I do my own cooking, cleaning, laundry, and shopping. I've been doing the garden with the others. I go to the Group Home on Sunday and Wednesday for a communal meal."

Albert does his shopping, cooking, and laundry with staff supervision and support. He also needs a bit of support with his appearance and cleaning. He gets his own giro, pays his rent and puts money aside for bills. He is self-medicating and gets his own prescriptions.

#### Daily Life

Albert went to Southwood Smith every weekday from 9.00 am - 4.00 pm. "We do dance, have meetings, pottery, and learning skills. I like it there. I work at the Centre one morning a week and I get paid for it. I used to go to St Andrews but it closed down. I didn't like it there so I stopped going."

"I usually go to the Day Centre in the morning and then come back here for lunch. I stay in the flat in the evenings. I don't watch a lot of television and I can't concentrate on reading. I like sharing things. I wish the Centre was open on Saturdays. On Sundays, I play football with some old friends from the area."

*Albert spends most evenings in the Group Home, socialising or watching TV because it is too lonely in the Bedsits.*

"We went to Devon recently for four days, I enjoyed that."

"I once went to a meeting of the Islington Forum but I didn't go again because I didn't want to get involved."

### Community Life

"I was born in this area but it was rough where I used to live. I don't have anything to do with the neighbours so I don't know if they are friendly or not."

*Albert talks to a couple of people in the street and he seems to get on well with people in the community.*

"I go to the Percy Arms pub sometimes but not on my own. I could go on my own but I usually go with the workers. It's all right there. I do my shopping at King's Cross. I go to Sainsbury's for my main shopping. There's a park at the roundabout but I never go there. There's a library at St John's Street but I don't use it. I don't go to church. I don't go to any cafes in the area because I don't need to. I go to the cinema and to the Youth Club to help out. We do a Christmas lunch for pensioners."

### Finances

"My pension pays for my rent and food and I have thirty pounds for myself. I had problems with the DSS but it's OK now. I spend most of my money on food. I don't smoke but I feel sorry for the men in the Group Home who smoke because they spend all their money on cigarettes. I could do with extra money."

### Professional Contacts

"My social worker visits now and again and so does June Smith from the Transitional Team. A woman also comes from the Community Team. I have a GP here but I get my injection and tablets at the Finsbury Health Centre from a CPN. I don't like the injection. I take the same medication as I did in hospital. I've been feeling quite well since I left but I still have low periods. I'm up just now."

*Albert has been to the Whittington Hospital a couple of times to see the Community Psychologist. He also sees the Community Psychiatrist.*

"I see the house workers most. There are quite a few of them. If I have a problem, I go to see my keyworker. The workers usually help me on specific things. The last time I spoke to my keyworker was when I was having a relapse. I had to go back to hospital for a few days. I just had to go back because I was ill but I was glad to get back to my flat."

*Albert was back in Friern for about two weeks. He had been living in the project for five months but became very down at the beginning of the year. Part of his problem was*



that his friend had had to go back to hospital and there was nobody else living in the Bedsits. Nobody from the house had any contact with Albert while he was in hospital and he recovered because he missed the project and wanted to come back. However, Albert hates violence and there are violent situations in the Group Home which make him depressed. Albert sees one particular resident as a trouble-maker and is afraid of him because he can be quite extrovert, psychotic, and powerful. He has been happier since this resident went back to hospital but another resident is also becoming violent. It can take Albert two to three weeks to recover from a violent incident.

#### Social Network

"I have friends in the area from before. I see them on Sunday to play football. I have aunts and uncles living nearby. I visit them every Thursday for a chat and they come to visit me."

Albert tends to go out to meet friends and relatives usually when there is an occasion, for example, a wedding, at Christmas. He visits an aunt regularly. He talks about friends at the pub and playing football but none of the workers have seen them.

#### Life in the Community v. Life in the Hospital

The only time I've been back to Friern is when I was ill for a few days. I don't think about the hospital now. My life is different now. I can go anywhere and I have plenty of time. I do more things, I have a job and more freedom."

*Albert is aware that he has a mental health problem but he does not like being mentally ill, so he saw being discharged from hospital as a good thing. He was out of the asylum and away from all the stigma associated with it. Albert is more relaxed and confident in himself. He laughs, talks, and participates in activities more. It would take something drastic for him to return to hospital now, but it will be years before he can move on because he always needs support and someone to talk to.*

#### Researcher's Observations

Albert was a very friendly, hospitable, and frank young man. He looked much happier and seemed much more alert and relaxed than when the researcher had seen him in hospital. He also seemed to have lost some weight. He proudly showed the researcher around his Bedsit which was clean, tidy, and homely. He seemed to enjoy the opportunity to talk about his experiences and was very pleased to receive the money.

#### Conclusions and Recommendations

Albert's schizophrenia seemed to have emerged after a series of stressful life events. He was only in Friern for two years but the negative effect of the institutional environment quickly took its toll, as seen in his huge weight gain. However, the hospital was a place which was far away from the community in which Albert's problems had arisen. He had friends there, got on well with staff, and enjoyed the social activities. As a result, he was sad about the hospital closing and leaving.

Albert had expressed a wish to move to the Group Home but because he was considered to be too able, he was prepared for a move to a Bedsit in the same project. Since there were long-standing vacancies in two Bedsits and Albert's friend who had occupied the fourth had had to return to hospital, Albert became very lonely and isolated and this led to depression, financial problems and, eventually, resulted in him having to return to Friern for a short stay. In view of the difference between Albert's life in hospital and living in the Bedsit, it seems that Albert's wishes should not have been disregarded - he should have first moved to the Group Home and, when he became more adjusted to life in the community, he could have been transferred to a Bedsit. Then perhaps his progress would have been smoother and he may have been able to move on to independent living earlier.

After 10 months in the community, Albert seemed to be well-settled. He appreciated the freedom and said he had forgotten about the hospital. He had a structured day, some paid work, and a good social network. He seemed fairly independent, although he visited the Group Home in the evening for company, and still needed some support from project workers with practical tasks and emotional problems. His progress may have been aided by the fact that he was returning to an area in which he had lived before. However, Albert was very negatively affected by violent incidents in the project which highlights the difficulty of providing community care in a group setting - the problem of one ex-long-stay patient can impede the progress of another.

Albert did not want to become involved in the IMHF probably because he considered it to be tainted with the same stigma as Friern. Since much of the Forum's work is concerned with eradicating the stigma attached to mental illness and some of the people attending the Forum hold professional posts, the researcher felt that Albert could benefit from attending this group and would recommend that he should actively be encouraged to do so.

The low-cost social activities in the evening and at weekends in Friern which Albert had enjoyed did not seem to be available in the community. If the more able and settled ex-long-stay patients like Albert are to make further progress and become more fully integrated in the community, they need to be given an opportunity to learn or re-learn the social skills required to take part in mainstream community activities in an environment in which they feel comfortable. The researcher would, therefore recommend the introduction of, for example, a subsidised weekend disco, evening social club, and sports/games afternoon which could take place, on a rota basis, at Day Centres.

## BRONWEN

### Background

Bronwen was 67 years old and single. She had been living in the community for three years when interviewed, but had had two previous placements. She had been in Friern for 40 years with a diagnosis of schizophrenia.

### Life Pre-Hospital

"I must have lived with my parents."

"I used to have a flat in Dulwich which had a television and telephone and everything."

*Bronwen lived with her mother and two sisters in Islington, and may have been in the ATS. She may also have had a sister in Dulwich whom she visited.*

### Life in Hospital

"I was in Friern since thirty-seven. I must have been a child but I can't remember. I had a tormenting time. There were problems with fur coats. There was prostitution, sex, people being killed. The men used to come. The babies were taken away. There were two babies, boys, I couldn't find them."

"Life was very normal in hospital. I worked in the laundry in the hospital. I used to like to go to the cafe and the Grocers Arms. I used to go to the South Workshop. Daisy was there. I loved it."

"I liked a man in the hospital, he was tip-top, and gave me money. The girls were my special friends, there was a dark girl, I don't know if she has gone to a flat or what."

"I used to go to A1 because they gave you a new ticket. I used to see Dr Anderson, who knew about the white god. She asked me 'will you be going on holiday this year or back to Friern'. If I had a problem, I went to a young girl, I think she was called Cindy."

"I felt a kind of a relief when I was told the hospital was going to close but it is so long ago now. I was told 'it is going to be a party for you', but I never got a party. I felt horrible about leaving the hospital but pleased at the same time because I was going to be on my own again."

Bronwen was in Friern for over 30 years. She may initially have been admitted because she was wayward. She had every sort of treatment in hospital - ECT many times and a lobotomy. She had sexual relationships with two men at Friern, one black and one Turkish. She claims she was raped in hospital and became pregnant. Her hospital records show that she gave birth to two sons, one black, one half-Turkish but not what happened to them.

Bronwen got on well with staff and patients because when she sees them now, they are friendly to her. Although Bronwen has a temper, people generally like her. She reacted very badly when she was told the hospital was going to close. She used to return to her ward after it had been closed and lie down on the floor where her bed had been.

## IN THE COMMUNITY

### Previous Placements

Bronwen's first placement was with Patsy and Stan, ex-Friern nurses. She did not appear to have been adequately prepared for the move and there was initially a problem with her smoking and safety. The placement eventually broke down because Patsy and Stan were a black couple and Bronwen had racist attitudes, possibly because she believed that she had

been raped by a black man in hospital. Another problem was that because Patsy and Stan were ex-nurses, Bronwen thought that she had to do what they said, as in hospital. Bronwen moved to another placement for a short time before moving in with the Sandersons.

### Domestic Life

"I lived in Walthamstow before. I've been living with the Sandersons for three years. I love it. The only think I do not like about living there is that the girls are afraid of me. Mrs Sanderson does everything for me. She gives me meals on a plate, cleans by room, does my washing, gets my cigarettes. I don't go shopping because Mrs Sanderson doesn't take me anywhere."

The Sandersons have grown-up children and a dog. They try to make Bronwen part of the family but she does not seem to want this. Mrs Sanderson has to restrict Bronwen's cigarettes for safety's sake. She was going to give Bronwen a cooker in her room but sometimes she is not in control and burns the pots. Mrs Sanderson does everything for Bronwen although she does try to encourage her to do little things, like wash some clothes, the washing-up. She can do things for herself, but not for long. Sometimes she will forget to put on underwear. When the Sandersons went on holiday, Bronwen went to live with a nurse near Friern.

### Community Life

"I like the Finsbury Park area. I go into a cafe in Finsbury Park to sit and drink and there is a man there who

wants to marry me. I like the people, my friends, and one has a beautiful dog."

"The only thing I don't like is the banging. I've told Mary Sanderson about the banging and Alfred (another resident of the project, also ex-Friern). I don't have anything to do with the neighbours. I'm worried about Mary kissing the babies."

"I have been to the pub round the corner but the man told me to get out of his house. I buy sweets from the shops. I go to the park on Saturday and to Wood Green. I go to church. The minister wants to help me. Pamela (keyworker) has taken me to the cinema."

*Bronwen is liked by people in the community but when she starts shouting, which she does sometimes, she draws negative attention to herself. She appears obsessed by sexual activity but fluctuates between continually wanting sex herself and then denouncing people who express the same desire. She does not know what a condom is but she seems to have been sexually active. Since Bronwen is so vulnerable, there is a fear that she will be picked-up by just anyone and that she could be in danger. She told her Day Centre keyworker a story about being raped recently, and she repeated the story so many times and described a house in Haringey so vividly, that the keyworker thinks it is a true story.*

#### Daily Life

"I go to Southwood Smith, Hanley, The Avenue and somewhere in Crouch End. I come to The Avenue every day except



Thursday because it is not open. I come on the bus. I love it here. I just sit about and do nothing but on Tuesday I have a massage. I go to the Smithfield Centre for dinner because they give you dinner for no expense which is great. I leave The Avenue at 1.30 pm and go home to Mary because she worries about my soul. I stay at home in the evening or go to the Hanley Club. I love watching television at home."

*The main work that Bronwen's keyworker at The Avenue does with her is around the topic of 'freedom'. Bronwen used to think that when she came to the Centre, she had to stay all day. The keyworker is trying to get her to come and go at the Centre without asking. She is also trying to combat Bronwen's racism - it is not so obvious now. Bronwen is generous and friendly, and gets on well with people at the Centre. She often leaves her handbag lying around and wanders off.*

*Before Southwood Smith opened, Bronwen used to wander the streets when The Avenue was shut, and there was some concern for her. It would probably be better if she went to Southwood Smith more often but she seems to like The Avenue. She used to go to cafes around The Avenue before the cafeteria opened in the Centre. Sometimes at the weekend, Mrs Sanderson gives her money to have Sunday lunch out because she likes that very much.*

"I went on a camping holiday with Jane Black once. I really liked it and would like to go again. All the men were after me because I was the only woman. There was a baby there, I think it was Jane's sister's and she was looking after it."

*Bronwen has also been to the Isle of Wight with the Wednesday Club that Pamela runs at The Avenue because there was a vacancy for a woman. She bought coloured socks and a money belt for her holiday. She loved it and looked really well. However, she seemed unable to do much for herself, for example, unpack her case, wash her underwear.*

### Finances

"I pay for my rent and food with my Old Age Pension. I did have money once but not now. I once borrowed money from Mr Thompson at Friern. I have borrowed a pound from Pamela to buy milk. I like milk but some somebody said 'your tongue is all white and furry'. I get one pound ten pence on Saturday, Sunday, and Monday. Mary gives me cigarettes. Mrs Sanderson sorts out my money."

*Bronwen is like a child in many ways when it comes to eating sweets and dealing with money. She sees other people with Pension Books and Post Office Books and she would like these, but she is really not able to control her own money. She has a little savings left which she uses to buy clothes at Charity Shops. Pamela, her keyworker, keeps a Savings Book at The Avenue and Mary Sanderson keeps another. They give her money when she needs it. Bronwen would have been eligible for a holiday and clothing grant but her social worker did not know about it. Pamela now tries to ensure that Bronwen gets what she is entitled to.*

### Medication

"I take pills now, they are OK but make me tired. They are different from the ones I had in Friern."

*Bronwen has had no problems with medication. She knows what her pills are and takes them, but Mrs Sanderson controls them and when she is on holiday, Pamela takes over this role.*

#### Professional Contacts

*"I used to have a social worker but he said he didn't want to see me any more. I see somebody called Clive. I don't know who my GP is but I think he is in Crouch End. I did hope to see a consultant from Friern but I am dead."*

*Bronwen's social worker left and she is waiting to be allocated another, although she probably does not need one. Bronwen has a GP in Crouch End but she does not have any contact with him. Her physical health is good, although she has had problems with her teeth. She has seen Dr Baxter at the Royal Northern once, just to see how she was getting on. She does not see any of the Community Mental Resource Team. She has not been to any meetings of the IMHF but she does not really like meetings, although she goes to her keyworker's Women's Group which is small, and sometimes to the Centre meetings at The Avenue.*

#### Social Network

*"I don't have any contact with my family. I don't know where they are which is a shame because I used to get five pounds from two of them at Christmas."*

*Bronwen has lost track of her two sisters. Sometimes she confuses her sisters with her two baby sons.*

"Friends. There was Patsy and Stan in Walthamstow where I used to live. That was before I was ill. I was helpless, I didn't wash myself and I was wasting away."

#### Life in the Community v. Life in the Hospital

*Bronwen likes living in the project very much. However, until a year ago, she still visited the hospital and went to the cafe. It seemed to have a hold on her, probably because she had been there for so long.*

"I like living with the Sandersons. I like The Avenue but then I can see the whole lot being moved around and I can't do anything about it. Then there are the gentlemen. I've only had problems with Pamela's money here."

"I have been back to Friern to visit to see a plump black man. I have been told, and I know, that I shouldn't go back there but I did. I don't know if my life is better now. There were doors to the mental home, now they are chucking them out and they can't take it. At that age, the people of England chuck you out. When I went to visit, the television was on and there was food and everything. Then they turned off the television and said 'out you go'."

#### Researcher's Observations

Bronwen was a friendly, well-dressed, cheerful woman who looked younger than her 67 years. Before the interview, her keyworker at The Avenue Day Centre advised that it would be necessary to keep her to the subjects of interest, as she tended to ramble. She did seem to stray from the subject a few times but was easily brought back. Bronwen had agreed to be interviewed when asked by her keyworker and the wealth

of material in her interview showed that she was well able to talk about her experiences. However, Bronwen's Adult Carer had previously said that she would not be capable and that she did not want to be interviewed. Bronwen said that she had enjoyed the interview and was delighted with the money.

### Conclusions and Recommendations

Bronwen was in Friern Hospital for 40 years. If she was admitted because she was 'wayward' then she was one of the many people who were detained in mental hospitals who would not, in more recent times, have been admitted, for example, the deaf, epileptics, mentally retarded, eccentrics, and those labelled 'morally deviant' in accordance with the standards of the time.

Referring to Chapter 7 on Friern Hospital, Bronwen had been the responsibility of several different administrations during her long stay. She would have suffered the overcrowded conditions and bombings of the Second World War and been the subject of, and witness to, many changes in the hospital over the years, as well as the recipient of a wide range of treatments as they became 'fashionable'. Bronwen had two children in Friern who were removed at birth and it also seems likely that she was the victim of rape.

Therefore, her reference to people being killed, sex, and babies were not 'ramblings', given her hospital experiences.

The hospital was the only world that Bronwen had known, and it was a place where she had had both a monotonous existence and traumatic experiences. This may explain the

ambiguity in her feelings about the hospital - 'life was normal' but 'I had a tormenting time', 'I was relieved about the hospital closing' but 'I felt horrible about leaving'. This would also explain why she continued to return to her ward after it had closed and why, although she liked living in the community, she continued to go back to the hospital and had to be told to leave.

Bronwen also made it clear that she perceived the injustice of forcing very long-stay elderly patients to leave a place which they had once been prevented from leaving - 'There were doors to the mental home, now they are chucking them out and they can't take it. At that age, the people of England chuck you out'.

The breakdown in Bronwen's first placement shows how difficult it is for very long-stay patients to adapt to life in the community. In hospital they were expected to do what they were told, in the community they are required to make their own decisions. The difference between the living environments of the hospital and the community, highlighted when discussing people in the Pilot Study in Chapter 9, is reinforced by the safety risk which Bronwen's smoking constituted and her 'shouting', which could attract a negative reaction in the community.

Apart from retaining a strong association with Friern Hospital, Bronwen seemed to be happily settled in the community. She had a structured day, good social network, made good use of places in the wider community, and enjoyed social activities and holidays. She had practical help from her Adult Carer, a high level of support from her Day Centre

keyworker, and access to additional professional support if required. Bronwen had not, however, received all the financial support she was entitled to. This was probably because she had moved to the community long before the Case Coordination system became operational which highlights the importance of such a system, and that it should have been implemented before people began moving out of hospital.

Bronwen could be quite childlike and vulnerable. This was not really a problem within the confines of the Day Centre or on supervised outings but, on her own in the community, Bronwen could be at risk. Her story of being taken to a house in Haringey and raped confirms this. It is difficult to know how to solve this problem. Since it had taken Bronwen a long time to adapt to the freedom of the community, it seems inappropriate to put restrictions on her movements. However, she must also be protected from people in the community who would take advantage of her vulnerability and do her harm.

According to Bronwen's keyworker, Bronwen's carers tried to make her part of the family but she did not seem to want this. The researcher did not conclude this from Bronwen's account. Mrs Sanderson gave Bronwen meals, did her laundry, and controlled her medication and finances, but the researcher thought that this was not much more than a landlady would do for an elderly lodger. It was certainly less than was expected of adult carers, since this project is likened to the fostering of children, and carers do not receive remuneration just for room and board. If Bronwen's placement was more like a home, and her carers more like a

family, she may be less likely to wander the streets which would reduce the chances of her becoming a target for people, especially men, who may cause her harm. The researcher would, therefore, recommend that Bronwen's carers be reminded of their responsibilities and instructed to make more effort to include Bronwen in their family life. This will become increasingly important as Bronwen becomes older and less physically able.

### ALEXANDER

#### Background

Alexander was 34 years old, single, and a Greek Cypriot. He had been living in a project in the community for 11 months at the time of the interview. He had been in Friern for six years with a diagnosis of schizophrenia.

#### Life Pre-Hospital

"I lived in the Whittington Hospital for two, three years, before that in the Clerkenwell area. I lived with my Mum, Maria Chistofanou, my brother Spiro and my sisters. I used to work in an old Tailor's shop. I did dressmaking and deliveries all round."

#### Life in Hospital

\*Alexander was quite able and socially skilled in hospital. The older men in hospital seemed to feel paternal towards him. He was in regular contact with his family in Finsbury Park and said that he often worked in his uncle's factory.



It was thought, however, that he just hung around the factory and that his uncle gave him cigarettes. He sometimes used to disappear and there was a question of whether he was at risk and involved in drug-dealing. He was sometimes incontinent for no physical reason.

\*Alexander had tried for most previous projects with little success because he never followed things through. After the hospital fire in November 1988, he became more consistent about attending groups and seemed keen on the project he eventually moved to. One of his good friends was also being considered for the project. He required structure to get him out of the hospital.

"I think I was in Friern for five or six years. Life was all right in hospital. We got more money, one pound fifty pence a day. I used to go out to work, sit in the gardens, have tea and cigarettes in the cafe. I went to Industrial Therapy and the South Workshop."

"We used to go out to Southend and Brighton on the coach. I really liked going on the coach to the seaside, you had your own bed in a dormitory."

"Some of my friends in the hospital are living here. Alan, Adam, Andrew, Angus. I still have two friends in the hospital waiting for accommodation but most have found accommodation."

"I liked the hospital staff, if you wanted seconds, you could tell them and they would give you more."

"When I was told the hospital was going to close, I was crying. I didn't feel very happy about leaving but the house is proving better."

## IN THE COMMUNITY

### Domestic Life

"I do cooking, cleaning, and washing clothes with the help of the others. We take it in turns to do the shopping one or two days a week. I spent some time in the garden planting flowers and a man came to sweep up."

### Community Life

"I think the area is nice. I used to live here before with my Mum. I like it because I knew it before. The neighbours are all right though if you have the radio on upstairs in the television room, the neighbour says 'can you turn it down, I'm trying to get some sleep'."

"I went to the pub once or twice before it was knocked down. When I went in there, I would look for a girl called Linda. I go to the shops at Chapel Market. There's a park down the road and a library at Finsbury Park. I go to church, sometimes I light a candle and pray to Jesus and Mary."

"I use a cafe in Finsbury Park where I used to work, next to my uncle's. Sometimes I would go in there nearly every day because I went to work up there. I sometimes go to the cinema when I have money."

### Daily Life

"Last week I got the sack from my job with my uncle. The minute I walked in there he said 'you don't want to work, you don't want to do anything'. That is what my uncle said, I don't know why."

"I don't go to any Day Centres. I went to Hillside House once and had a cup of tea at two o'clock. I don't go to Hillside House every day because I don't know the people. That time I went I said 'Is it all right if I go home now' and they said 'If you want'. That is the only time I ever went there. I used to go to Peter Bedford's at Finsbury Park. It was all right, I used to get paid in dinner cheques. I wouldn't mind going to Day Centres to play a game of cards or if there was Monopoly. I would go to Day Centres at nights or weekends if I liked it."

"Before I would get up and go to Finsbury Park to work. In the evening I would sometimes go to the pictures or have a pint, or go to a club, that sort of thing. On Sunday, my sister comes in the car and they take me shopping."

"The rest of them went to Devon for a holiday but I didn't go. I had a card from there (he showed the researcher the postcard). I said I didn't want to go but I wished I had gone. I will have to wait til next year now."

"I watch television. I have read a couple of books upstairs. Sometimes I go swimming and kick a ball around. I really like going out to Clubs, to Finsbury Park gambling houses just to watch people playing."

Alexander had never been to the IMHF.

### Finances

"I get a Pension Allowance. I get sixty three pounds ten pence cash on Wednesday. I owe fifty pounds for my rent. I have to pay that. I havn't had any problems with the DSS. I just got one hundred pounds to buy clothes. I had to

throw the shoes away, the worker said I shouldn't wear the boots but the shoes were no good. I spend one pound a day, I'm happy with that."

#### Medication

"I take the same medication as I did in hospital. I have been feeling a little better since I've been living here but I have had the same problems."

*On the whole, there have been no problems with Alexander's medication. However, when he does not take it, his aggressive side comes out. He became very aggressive for a week, he was disruptive, bullied other residents, and damaged part of the kitchen. There was also an incident with a knife.*

#### Professional Contacts

Alexander had a social worker. He did not see any members of the TT or the CMHRT.

"I have a GP called Dr Brown. I also have a private doctor, Dr Stephanos at 80 Hornsey Road. I prefer him. When I have a tummy-ache or I hear voices, I can go to him. I like Dr Baxter, I see her on a Thursday or Friday."

"I used to go to the Whittington five or six years ago for injections. I was there for two or three years waiting for a transfer to Friern. It was all right there, I had friends, but they thought it would be better if I got to know the people at Friern."

"If I have a problem, I contact a worker, James or Nigel. They are not much help. The last time I went to see them was about money. They were all right."

Social Network

*Alexander is in regular contact with his family who live in Finsbury Park.*

"I have family in the area, my brother had a house at Highbury Corner. His wife sold it and bought a house in Manchester and wanted my Mum to live with them there. I was worried about that. My Mum lives in Finsbury Park. They come to visit and I go to the factory where my Mum works. They give me money for cigarettes. Every Sunday my Mum and sister come and give me money for cigarettes and take me shopping. I also have a nice friend but his swearing is something else."

Life in Hospital v. Life in the Community

"I like living here. I have not been back to Friern since I left. I do not visit there. The ward I used to be on burnt down and my friend, a young man called Mr Patel, died. Sometimes I want to go to Friern to visit but something inside says I must not go back. I don't know why. My life has been the same since I left hospital."

*Alexander's cleanliness, personal appearance, and communication are better now, due to the input of one particular female project worker. It is suspected that Alexander has fallen in love with her because of all the attention she has been giving him.*

Researcher's Observations

The first time the researcher met Alexander at the project, he was friendly, cheerful, and very cooperative when another resident insisted on changing interview times with him.

When she met him the second time to conduct the interview, he was still friendly, but seemed very agitated and depressed, in fact, he looked the same as he had done in hospital. His room in the Group Home was sparse and smelled strongly of disinfectant. He seemed very agitated throughout the interview, but said he had not minded talking to the researcher. He was very grateful to receive the money for participating.

### Conclusions and Recommendations.

Rather ironically, Alexander was moved from a small hospital in Islington (the Whittington) to a large institution in outer London (Friern), so that he could become part of the latter's closure programme and be discharged to a residential project in the community (Islington).

Alexander was very upset about the closure of Friern because he had been there for six years and liked every aspect of hospital life. If it had not been for the hospital fire, he may have continued to resist the idea of leaving. The shock of leaving the hospital was possibly softened by moving to the project with people he had been well-acquainted with in hospital, in an area which he liked because he had once lived nearby with his family.

After 11 months out of hospital, Alexander continued to need domestic, administrative, and emotional support. He admitted he had the same problems as he had in hospital, and the researcher did not detect any positive change in his outward appearance and behaviour at the time of the interview. The smell of disinfectant in his room suggested

he still suffered from incontinence and, during a period when he stopped taking his medication, he became aggressive. Therefore, it seemed unlikely he would be able to move on to more independent living in the near future.

Most of the professional support Alexander received came from the project workers, therefore, he was very dependent upon them, especially one worker who had given him a great deal of attention. This again shows the importance of having permanent staff in a project because if, for example, this worker left while Alexander was still adjusting to the shock of leaving the hospital, this could have a very negative effect on him.

Alexander seemed to make good use of places in the wider community but, if it were not for regular contact with his family who also gave him financial support, and his friends in the project, he would have a very socially isolated existence. As a result of this and the recent 'sacking' by his uncle and, in view of the social life and paid work he had enjoyed at Friern, Alexander's life in the community did not compare favourably with his life in the hospital, albeit that Alexander was beginning to feel more positively about the former.

The researcher was surprised that Alexander did not seem to have any contact with the TT or CMHRT and would, therefore, recommend that Alexander be actively encouraged by the latter or the project workers to attend Day Centres and be given the opportunity to undertake some paid work. This would give him some structure to his daily life, help him to increase his social network and, hopefully, by

forging stronger ties with the community, he may begin to lose his association with Friern Hospital.

## ARCHIE

### Background

Archie was 64 years old, single, and he had been living in a project in the community for 11 months at the time of the interview. He had been in Friern for 24 years with a diagnosis of schizophrenia. \*He suffered some spasticity due to tardive dyskinesia, and had a speech impediment also due to tardive dyskinesia or a head injury.

### Life Pre-Hospital

"I used to live in Carlton Terrace with other people. I don't know if I had any jobs but I went to Day Centres."

### Life in Hospital

\*Archie was very quiet and compliant, and needed a lot of motivating. He was physically visible because of odd posturing and facial movements. He appeared vulnerable but had strength of character. While in hospital, he had no contact with his family.

"Life was all right in hospital. I went to the North Workshop in the winter. I didn't have any special friends in hospital but I got on all right with hospital staff. Is the hospital going to close?

I felt OK about leaving, I havn't been back since I left."



### Preparing for the Move

\*There was concern about Archie's frailty and his ability to self-medicate. A Charge Nurse tried to get him to come and get his own medication and read the doses but he sometimes forgot and sometimes the tablets ended up on the floor. She recommended injections instead of oral medication. He also needed prompting to change his clothes.

### IN THE COMMUNITY

#### Domestic Life

"I've been living here since it opened. I cook, clean, and wash my clothes. I go to the supermarket with the others. I did gardening once."

#### Daily Life

"I go to Southwood Smith all week in the upstairs part. It is all right."

Archie goes to the Day Centre with another resident.

"I sometimes watch TV and I read books. At the weekend I just sit about. I went to Cornwall."

#### Community Life

"I like the area. I go to the shops, park, and library."

#### Finances

"I haven't had any problems. I don't smoke, I spend my money on Mars bars."

#### Professional Contacts

"I haven't seen anybody from the Transitional Team lately, I get on well with June. I see Dr Baxter, I like her. I

mostly see my keyworker. I tell the keyworker if I have a problem."

#### Medication

I think I have the same as in hospital. I've been feeling all right."

*After a period of being bullied and terrorised by another resident in the project, Archie did not take his medication and he became very agitated and disturbed. It took him half an hour to make a cup of tea. He had to return to Friern for a short time.*

#### Social Network

"All my family are dead and buried, dead and buried, but I have a sister Julie in Australia."

#### Life in Hospital v. Life in the Community

*Archie loves living in the project. Many years ago, it would never have been expected that Archie could live in the community but he has done extremely well and there is now the possibility of him moving from the Group Home to the Bedsits.*

"I like living here very much. I still feel all right about the hospital but I wouldn't like to go back now, no I wouldn't like to go back.

#### Researcher's Observations

Archie was friendly and looked well. He did, however, carry out some ritualistic cup-washing and water-drinking before the interview began. He had a lot to say but, because of his speech impediment, the researcher found it difficult to

catch everything he said, although her understanding grew as the interview progressed. He was very happy to receive the money for participating.

#### Conclusions and Recommendations

Archie had been in Friern for a very long time. As a result of his initial illness and the side-effects of medication, he would probably have been considered difficult to rehabilitate, and the longer he remained in hospital, the more institutionalised he became and the smaller his chances of leaving would have been. If it had not been for the closure programme, Archie would probably have died in hospital.

Archie did not appear to have any negative memories of Friern but he was adamant that he did not want to go back, and denied that he had been back. Also, he did not seem to know that the hospital was going to close.

As a result of the negative side-effects of medication, Archie suffered from tardive dyskinesia. His speech impediment made it very difficult to communicate with him, and his odd posturing and facial movements could make him more visible in the community and, consequently, more vulnerable. Indeed, he even seemed to be vulnerable in the project. As a result of being terrorised and bullied by another resident, Archie stopped taking his medication and became so agitated and disturbed that he had to return to hospital for a short time. This again shows the problem of providing community care in a small group setting and how

people with multiple disabilities can easily become victims in the community.

Nevertheless, Archie seemed to be happily settled in the community. He attended a Day Centre daily, so there was structure to his daily life. He had a high level of professional support when he first left the hospital which began to taper-off as he became more able. There was also the possibility of him moving on to more independent living, which would indicate very significant progress for someone who had been forgotten in hospital and who would, therefore, probably never have left.

Archie, however, had a small social network in the community. He had no contact with his family and his only friends lived in the project, although he may make new friends in the Day Centre he was attending. Archie also had little to look forward to in the evenings and at the weekends. The researcher would, therefore, recommend that Archie be allocated a Befriender who would, in view of his speech impediment, take the time to learn to understand him. Also, he should be encouraged to attend The Avenue and Hanley Road Day Centres on Sundays, to further break the monotony of the weekends.

#### ADAM

##### Background

Adam was 33 years old and single. He had been living in a project in the community for 10 months at the time of the

interview, and had previously been in Friern for four years with a diagnosis of schizophrenia.

### Life Pre-Hospital

\*Adam had a long history of contact with the Mental Health Services. At four years old, he was sent to Child Guidance who gave an uncertain diagnosis. His mother had wanted a daughter and dressed him like a girl, then when he acted like a girl, she chastised him. He consequently suffered from an identity crisis which was manifested in behavioural problems. The family had lived in the Barbican, not far from the project he eventually moved to.

"I used to live in City Road with my Mum. I used to be a student nurse, well a helper."

### Life in Hospital

\*Adam's behaviour alternated between that of an impulsive and quick-tempered three year old and that of a fifty year old. He sometimes adopted infantile posturing and was socialised into the institutional setting. Adam was well-known and liked within the hospital. He had a good social network and seemed to occupy himself well. He continued to have a close but unhealthy relationship with his mother and sister, who were both impulsive and bad-tempered. When his sister moved to Kent, she became less involved in Adam's life but his mother continued to be a very important influence.

"Looking back, life was terrible in hospital. Sometimes you didn't get a cup of tea from breakfast til

late. That was too long. Here you can make a cup of tea when you want."

"I used to go to the Margery Street Workshop. I had one special friend, Rosie, a helper. Some hospital staff were good, some were bad. I spoke to my social worker when I had a problem."

"I felt terrible when I was told the hospital was going to close and I felt terrible about leaving."

### Preparing for the Move

\*Adam was keen and willing to leave hospital but his mother and sister did not want him to move to the project. His mother was now living with his sister in Kent. They wanted him to remain in hospital, probably out of guilt. His sister became amenable to discussion but his mother was not. They tried to find a placement in Kent for Adam, but as the outcome was uncertain, he was prepared for a move to the Group Home with the possibility of moving to the Bedsits.

## IN THE COMMUNITY

### Domestic Life

"The food is good here and the company is good but I don't like it when people shout, like tonight."

### Daily Life

"I work on the Reception at Southwood Smith every lunchtime from 12.00 to 1.00, for two pounds 50 pence. That is the time that nobody wants to do it. I think the Centre is very nice and I get on very well. I would like to go to a Day Centre at the weekend, Saturdays and Sundays. I go to the

Day Centre until 4.00 pm, then come back to the house for tea. I watch TV in the evening cause I have no money. I watch a lot of TV. We went to Invercombe for a week."

Adam did not go to any meetings of the IMHF.

#### Community life

"I think the area is nice. I particularly like the garden, the atmosphere, but it is too closed. I don't have anything to do with the neighbours. I keep myself to myself because I can't manage anything else yet. I occasionally go to the pub next door. We go to Sainsbury's at the Angel and Chapel Market for shopping. I go to church every Sunday."

#### Finances

"I have spent all my money. I pay fifty two pounds for accommodation and food and I have ten pounds forty pence left. I spent most of my money on cigarettes."

#### Professional Contacts

"My social worker Jasmine left. I saw the Transitional Team from 1987 to 1991 but not now. I have a GP, Dr Silver, who is very hard. I don't see him often at the practice. I see Dr Baxter every two weeks, I like her."

"I have an injection from the CPN every fortnight. I have more medication now to keep me calm. I've been feeling very depressed since leaving Friern. I haven't been back to Friern since I left."

"If I have a problem I talk to the keyworker, who helps. The last time I spoke to the keyworker, it was about finances."

### Social Network

"I moved to the project with some men I knew in hospital."

*Adam is quite a powerful person in the Group Home and he has been disturbing at least one of the other residents for some time.*

"I don't have any family or friends in the area. My family are in Kent but I don't see them very often. The last time was Christmas when they visited. My mother is now in Kent. She has been very ill for a couple of weeks with high blood pressure. I am very worried, very worried."

### Life in the Community v. Life in Hospital

"I feel bitter about the hospital now. My life has been better since I left. This is the start to a new life."

*Everything was new to Adam when he first moved into the project and he has had to make the usual adjustments. He is no longer on medication and is doing very well in the project so there is a possibility that he could move to the Bedsits in time.*

### Six Months after the Interview

*Adam is now in the Maudsley Hospital. His mother and sister mean well but they seemed to be resentful of him living in the project. They felt that life was too Bohemian in the project and they did not accept the staff because Adam was being encouraged in his homosexuality. They wanted to repress him. His sister removed him from the project and insisted that he be re-diagnosed. She suspected that he had autism because her child had been diagnosed as autistic and she was looking for a genetic connection. However, there is*



the possibility that Adam has a low IQ. Adam is fond of his sister and because he did not want to fall out with her, he complied with her wishes, even though he did not want to leave the project and lose his freedom.

Adam's mother and sister are currently trying to get him into another home, but the cost may be a barrier. His room in the project has, so far, been kept for him.

#### Researcher's Observations

Adam looked well when the researcher first spoke to him, but when the time for the interview arrived (two hours later), he was wearing his pyjama jacket and seemed very sluggish. He became very agitated after the first ten minutes of the interview and said he was desperate for a cigarette. After having a cigarette, he became incoherent for about five minutes. He was very upset when talking about his mother and afterwards moved his chair very close next to the researcher, adopting a rather childlike pose, and began staring at her which made her feel uncomfortable although not threatened. He became very agitated again near the end of the interview and seemed relieved when it was over. He was very pleased to receive the money for participating.

#### Conclusions and Recommendations

Adam had a long history of mental health problems which seemed to stem from childhood identity problems, created by his mother. His ongoing relationship with his mother and later his sister did not appear to have been in his best interests. They tried to prevent him moving to the community and once he was beginning to become settled, they

removed him from the project and had him admitted to another psychiatric hospital.

Adam's feelings about Friern Hospital were ambiguous. His life was terrible in hospital, he had not been back since he left, and he felt bitter about the hospital looking back. However, he felt terrible about leaving and had been depressed since he left. This ambiguity may have been a reflection of his family's opinions of his move to the community and/or a result of ongoing identity problems.

Adam had a structured day in the community and a good level of professional support. He did not have enough money to join in activities in the wider community although he himself did not yet feel ready to make individual use of the community. His social network was confined to living in the project and some unhealthy family contact, as seen in his distress when talking about his mother, and his rather childlike behaviour afterwards. It seemed, however, that Adam was a powerful personality in the project who made trouble for other residents - another example of the difficulty of providing community care in a group setting.

Nevertheless, Adam was beginning to settle in the project which was in an area close to where he had lived before his admission to hospital. His progress may be due to this familiarity and because he regarded his move to the community as a positive step. He appreciated the freedom of life in the community and considered living in the community to be the start of a new life. It was anticipated that he would be able to move on to more independent living in time

but, instead, he was taken away from this new life by his mother and sister for their own motives.

When the researcher heard the objections made by Adam's mother and sister when he was being considered for the project at the Project Groups Meetings, she would have recommended a Guardianship Order for Adam on the grounds that their objections were irrelevant or contrary to the future well-being of Adam. If a Guardianship Order had been obtained at this time, it would have difficult for Adam's family to negatively intercede further in his life.

Even if Adam was eventually to return to the project, his progress was likely to have been severely impeded by his re-hospitalisation, and there was no guarantee that he would not suffer from further family interference which would not be in his best interests in the future.

## BELINDA

### Background

Belinda was 51, single, and originally from Dominica. She had been living in a project in the community for two years at the time of the interview but had previously had a short stay in another project. She had been in Friern for a total of six years with a diagnosis of schizophrenia.

### Life Pre-Hospital

\*Belinda had had mental health problems for many years. She was married/co-habiting.

"I used to share and I did work."

### Life in Hospital

"Life was all right in hospital. I used to go to the South Workshops. I used to like working and I got paid. Everyone in the hospital was friendly. Sometimes I go back to the hospital to visit friends who are still there. I got on with the staff. They me told me that they couldn't have me back in hospital because it was going to close."

"I felt all right about leaving. I came straight to the project I'm living in now."

\*Belinda stayed in her first placement for four months. It did not work out because it did not offer enough support, she had wanted a more communal environment and was unhappy about being on her own, and she was not good at taking responsibility. She returned to hospital and stayed there for nearly a year waiting for another placement.

\*Belinda's relationship with her family was not very good. They had many long-standing problems which social workers felt should be resolved before she was approached about leaving the hospital for a second time. However, she was desperate to leave, and there was some urgency about finding her another placement because she had already been living in the community. Consequently, she was being considered for two projects concurrently. She was approached about filling the vacancy in the project in which she now lives via the Users and Women's Groups at The Avenue Day Centre.

## IN THE COMMUNITY

### Domestic Life

"I do cooking, shopping and gardening with other people in the house. I clean my room and do my own laundry."

### Community Life

"I think the area around the project is perfect, very rich. It is all right for the bus and tube. I have nothing to do with the neighbours but they are very friendly."

"I go to the local pub every two weeks. The drink is all right but very expensive. I sometimes go to the local shops on my own but they are very expensive. I sometimes go to Highbury Fields or Finsbury Park in the summer. I've been to the library many times, the Central Library, for books but mostly for cassettes. I go to church regularly. I buy Coca Cola in the shops and I use the cafe at The Avenue. We sometimes go to the cinema as a group from the house."

### Daily Life

"I used to do painting for my social worker and he used to pay me. There used to be a regular painting class at The Avenue but it is not so frequent now. I would like to go to do painting again at the Centre. There are a lot of groups at the Centre. On one I just read the paper. I generally come here (The Avenue) in the morning about 10.00 and stay until 11.00 or 12.00. Then I go home or to the betting shop, and then home at 4.00. Sometimes I have lunch at the Centre."

*Belinda attends The Avenue regularly but she can be unreliable. There are still art classes at the Centre but Belinda does not attend them.*

"In the evenings, I stay indoors. I sometimes go out at the weekends. We go on outings from the house. We went to Brighton for four days and Folkestone for a week. It was magnificent."

"I watch quite a lot of television, read, and listen to music. I like watching football very much and I really like betting."

"I've been to some groups organised by the Islington Mental Health Forum and they were all right."

#### Finances

"I am able to manage. I have not had any problems. I spend most of my money on clothing."

#### Professional Contacts

"I have a new social worker. I last saw him four months ago. I see members of the Transitional Team when they visit the Centre. I sometimes see the Community Team for a chat. I go to my GP regularly and a CPN. I see Dr Baxter sometimes. I go to the Whittington if I'm not well. I tell my keyworker or another member of staff at the house if I have a problem, they usually sort things out."

#### Social Network

"I have some friends living in the area. I see them quite often. I visit them and they visit me for tea. I also see my family a lot. They don't live in the area."

Life in the Community v. Life in the Hospital

"I like living in the project very much. I feel all right now. I havn't had any problems living there. I've only been back to Friern for a visit. I still feel all right about the hospital."

Researcher's Observations

Belinda was relaxed and friendly in the Day Centre Cafe before the interview began. She had just returned from having an injection at the hospital. The only room available for the interview was a very small side-room. It was a very hot day and Belinda began to perspire heavily about halfway through the interview. She seemed to be in some distress but when the researcher asked her if she wanted to stop the interview, she said she wanted to finish it. She was very pleased to receive the money for participating, and returned to her former self on leaving the room.

Conclusions and Recommendations

It seemed that the reasons given for Belinda's first placement in the community breaking-down could have been foreseen, since the level of support and the type of living environment had already been established before representatives of the managing agents visited the hospital to recruit patients for their project.

Belinda's return to hospital, when her first placement broke down, was likely to have had a negative effect on patients who had been in Friern for a much longer time, and who were more anxious about leaving. The fact that Belinda

had to stay in Friern for a year before another placement became available and that she was then considered for two placements simultaneously was likely to have had an unsettling effect on her. This may explain why Belinda made no mention of her first placement.

After two years in her second placement, Belinda seemed to be quite settled in the community. She appeared to have a good social network of family and friends, some individual structure to her day, and no financial problems. However, she still seemed to enjoy returning to Friern to visit. She also still required quite a high level of support and, in view of the breakdown of her first placement, it seemed unlikely that she would be able to move on to less supported accommodation in the near future.

Further, Belinda did not have any real substance to her day-time activities. In Friern, she had enjoyed her paid work in the South Workshop. Previously at The Avenue, she had attended regular painting classes and her former social worker had paid her for some of the work she produced. The fact that Belinda said she would like to do painting again but no longer attended the Art Classes at the Centre suggested that 'paid work' was her motivating factor. The researcher would, therefore, recommend that Belinda be given the opportunity to undertake some paid work in the community, perhaps in The Avenue Day Centre which she had grown accustomed to attending regularly, to help her to break her tie with the hospital and enable her to become more independent.



## ANDREW

Background

Andrew was 44 years old and single. He had been living in a project in the community for 11 months at the time of the interview. He had previously been in Friern for 14 years with a diagnosis of schizophrenia.

Life Pre-Hospital

"I used to live with Mummy and two brothers in Essex Road. My parents separated when I was small and I went into hospital when Mummy died. I was suffering from depression but they said it was schizophrenia, but it wasn't. I am not schizophrenic."

"When I was 15 I worked in the Post Office. I rode bicycles then I worked in warehouses and kitchens."

Life in Hospital

\*Andrew was very sociable in the hospital and liked betting. He was like an adolescent in many ways. He wore half-mast trousers and changed his name. He got a clothing allowance but sold his clothes to another patient. He required a structured day and to be closely monitored.

"I was in Friern from 1976 to 1990. I was always a voluntary patient. I liked the hospital when I was there but I wouldn't like to go back again unless visiting."

"I went to the South Workshop but it was boring, sitting down all the time, fiddling about. Then I worked in the stores. They were fine, you weren't sitting down but meeting people all the time. I did that for four years for five pounds a week."

"I liked the discos in the hospital, in the Orchard Canteen. I had some friends in hospital who are still there."

"I got on OK with the staff and still see some of them when I visit. If I had a problem I would tell the nurse on the ward or a social worker on the Islington Team."

"When I was told the hospital was going to close, I regretted it because I liked visiting there, although I don't want to go back now. I liked the way it was built. I had to wait two years for the project to be ready but I was so glad to leave."

\*Andrew was very anxious about leaving hospital because he felt he was too ill to leave. However, after the hospital fire, he said that the project looked nice and asked a social worker to help him leave. *Andrew moved out of hospital with great difficulty.*

## IN THE COMMUNITY

### Initial Problems

*Andrew went back to Friern every single day when he first moved into the project. He had frequent but informal contact with the hospital, where he cadged cigarettes, for 16 months after moving out, even though he would return to the project to take his turn at cooking every week. He also initially had a problem with incontinence.*

### Domestic Life

"I like the house and I like the people here. I don't like Friern any more. We take turns with cooking, cleaning, and shopping. I do my own laundry in the washing machine. I

cook on Wednesday and clean on Saturday. We all get involved in the garden. I got an extension and cut the grass on one side."

"I go to Southwood Smith and Hillside House one or two days a week. I don't go regularly yet but when I do, I will get paid like Albert. He gets seven pounds a week. It is a lovely Day Centre. I like Tracy and Pauline. I haven't been to The Avenue yet. I would like the Day Centres to be open at night and at the weekend."

"The rest of the time I go to Friern. I like the hospital but it will be closing soon. I go to Friern five days a week including the weekends. There is nothing to do in the evenings. I have a free travel pass so I can go to Friern for the day. I come back at 9.00 or 10.00 or even 11.30 pm but I can only use the bus permit until midnight."

*A few months after the interview, Andrew started going to the Hanley Road Day Centre and began earning money for cleaning the toilets, a job which he does diligently.*

"I didn't go on the holiday to Devon. I'm afraid of accidents on the motorway so I didn't want to go in the mini-van because I don't want to die."

"I watch TV. I like the news, soap operas like Neighbours and Home & Away. I also like documentaries like World in Action. I watched the Panorama about Friern closing a couple of weeks ago. I read newspapers, not books because they are based on fiction and are not real."

"Physical activities bore me but I like horse racing. I don't go to the races because the betting is better in the Betting Shop and you get a better view on the screen."

"I really like talking to people, especially women."

Andrew does not go to any meetings of the IMHF.

### Community Life

"I like the area because I like Islington. I was born in Essex Road. I like the houses round about. I speak to one neighbour, Lizzie, across the road. She is young. I said hello to her when I moved in. The neighbours seem to be friendly."

"I don't go to the pub because I don't drink. I just smoke and bet. I go to Stanley's Betting Shop on the corner but I prefer Ladbrokes at Friern."

"I go shopping at the supermarket and Chapel Market, but when we only need something little we go to the Amwell Stores. I go to church but not regularly. I go into a cafe at Friern after the Betting Shop."

### Finances

"I get sixty three pounds a week. Fifty two pounds 50 pence goes on rent and food so there is only ten pounds 30 pence left for betting and cigarettes."

### Medication

"I havn't been taking any medicine for eight years but my injections are the same. I have been feeling wonderful since living here."

*Initially, Andrew adamantly refused all medication but since having a regular injection he has improved.*

### Professional Contacts

"I have a social worker, Brian, at the Neighbourhood Office. I see the Transitional Team at Friern. They let me come up for a cup of tea in A1 on Tuesdays. I saw Emily today. I see Jennifer from the Community Team. My GP is Dr Wood at Pine Street. I see a lot of the support workers. I see Dr Baxter at Pine Street every three months. I get on well with all of them but I really like the people at Friern."

"If I have a problem, I tell my keyworker, George, and he helps. I last spoke to him about a problem two weeks ago. I had betted two weeks rent money. Now I'm paying it back so I only get 70 pence a day which is why I have no money and wanted the money tonight. I've learnt my lesson, I won't do that again."

### Social Network

"One of my brothers is in Shoreditch. That is Clive. He rang up but he hasn't been to visit yet. My other brother used to visit me in Friern but he is in a hospital in Surrey now. That is also a psychiatric hospital. I see former patients at the Angel."

### Life in Hospital v. Life in the Community

"There's more freedom in the community. It's better now. I like the community. I havn't been back to Friern apart from visiting. I still like the hospital but I don't want to go back there to live. Friern was one building, you were clogged in there. You didn't meet people. Here there is more freedom and more people."

Andrew took a long time to adjust to life in the community. When he first moved into the project, he was a very isolated, solitary figure. He has benefited from finding a routine. He gets on well with the staff and is beginning to make friends now. He is much smarter now in his physical appearance and there is the possibility of him moving from the Group Home to the Bedsits in time.

#### Researcher's Observations

Andrew was very friendly, as he had been in hospital, but he was much more tidily dressed. He was desperate to receive the money for participating and felt that the project workers had perpetrated an injustice against him by trying to make him wait until another evening for his interview. He continually shouted his concerns about this during the interview and also seemed 'paranoid' when he heard some boys yelling in the street. He said he had enjoyed the interview and that he would like to do it again. He was delighted with his money.

#### Conclusions and Recommendations

Andrew appeared to have developed schizophrenia following the shock of his mother's death. He had a brother who also suffered from mental health problems which suggested that there may have been a genetic propensity towards schizophrenia in the family, which was triggered-off by a stressful life event - the mother's death.

Andrew was in Friern for 14 years and was completely entrenched in hospital life. He got on well with staff and enjoyed his work in the Stores. It is, therefore,

understandable that he was anxious about the hospital closure and that he did not want to leave. It seems that the unsettling effect of the Hospital Fire in 1988 strongly contributed to his change in attitude to leaving, but it must have been very difficult to sustain his interest in the project when its operational date was delayed due to problems in recruiting staff.

Andrew's long stay in Friern and involvement in hospital life would explain why he had retained a connection with Friern, but not the strength of this connection, especially since he had moved to an area in the community which he knew and liked because he had once lived nearby with his family.

At first, Andrew returned to Friern every single day, generally only coming back to the project late at night. After 11 months out of hospital, Andrew said he liked the freedom of the community and living in the project, and he was adamant that he did not want to go back to the hospital to live. However, he was still visiting Friern regularly and obviously needed a strong motivating force to enable him to break his tie with the hospital and forge one with the community.

In view of his past record of work in the hospital, his expressed desire to work in the community, and the financial problems he had experienced, the researcher would have recommended that he be channelled to paid work-related activities in the community, with some urgency. Five months after the interview, Andrew was undertaking paid work at a Day Centre with positive results - improvement in his

outward appearance and behaviour, reduction in the frequency of his visits to Friern, and the possibility of moving on to more independent living.

If it had not been for Friern's closure programme, it is unlikely that Andrew would ever have left the hospital. He had initially had a lot of professional support in the community and the progress he had made led the researcher to question why he had not been the subject of intensive rehabilitation before he became so entrenched in hospital life that he became difficult to discharge and unwilling to leave.

#### ADRIAN

##### Background

Adrian was 34 years old, single, and Irish. He had been in Friern for five years with a diagnosis of schizophrenia prior to moving to a project in the community. He had lived there for three years, and had been living independently in an Islington Council flat for six months at the time of the interview.

##### Life Pre-Hospital

"I was born in London but lived in Ireland."

"Before I went into hospital, I worked at Holborn in Bruce House for two or three years, I think. It was a hostel for down and outs, and homeless people. When I first worked there, I lived in and rented a cubicle, but it was pretty rowdy there. I did all sorts of work there,



portering, laundry, dining-room, kitchen, tea-boy. I was very overworked and stressed. The hostel was full of down and outs so it was very depressing. There was a murder there. I had to wake them up in the morning to get them out. I was firm and I would never hit them because I was sorry for them, but you had to get them out. I saw the blood and went to get the manager. It was a shock. It was manslaughter. Somebody had used the scaffolding which was outside the window. It was dangerous. I started to have blackouts after that. By that time I was living on my own in a flat in Archway."

#### Life in Hospital

"I was in Friern for five years. Life in hospital was terrible. I hope I never see the inside of a hospital again. I felt that the hospital was a punishment. I couldn't help being ill. I didn't want to be sick. It wasn't my fault."

"Friern was gloomy and run down. The food was terrible. One day we had spinach in a white sauce, it was as hard as a rock. It would have made a dent in the wall."

"I worked in the Main Stores with the porters transporting medicine boxes and dinner boxes. The porters were nice to me, we played cards, sat drinking coffee. I used to go the Turrets pub. I didn't like any of the activities in the hospital."

"I had friends in the hospital and I think some of them are still there. I don't go to visit them because I hate the hospital. I got on well with the nurses because I

didn't bother them. If I had a problem, I would contact my social worker, Gordon. I saw him once a week. I think he has gone to Manchester now."

"I was on medication for five years. I had it in the rear. I was like a zombie and it made me feel worse. What I really needed was a Counsellor. I had minor problems and needed help with them but instead I got doctors. I tried to commit suicide four times. I had a problem with the doctors. They used me, they couldn't do anything for me. It was demonology."

*In hospital, Adrian sometimes used to stick pins into himself and he had violent episodes. He thought he was a guinea-pig for medication in hospital which is why he thinks he has been used.*

"I felt worried when I was told the hospital was going to close. I wanted to leave but I had become institutionalised and addicted to the medication. If it hadn't been for the project workers, I would still be in Friern. They came every week. They said I would have to leave the hospital some time and helped me to leave by giving me confidence."

"I still felt worried when I left the hospital because I had become so institutionalised that I didn't want to leave. When I first left Friern, I used to go back to visit the porters and staff and nurses but I haven't been back for a long time."

## IN THE COMMUNITY - LIVING IN THE PROJECT

### Domestic Life

"I lived in the project from 1988 to 1991. I didn't like living there because of the other residents. The housing workers were OK. I had my own room and did everything for myself - cooking, cleaning, laundry, shopping."

*When Adrian moved into the project, he relied on the staff a lot for administrative support, for example, sorting out his DSS, making an appointment with the dentist, but not for emotional support. That was because he was adamant that he was not ill, and moving to the project reasserted this contention. He had no problems with practical chores.*

### Community Life

"I liked the area around the project but I didn't like the neighbours. I had problems with the neighbours but I always have problems with neighbours. The neighbours ignored me, they didn't want to know me. I think that is a bad attitude. I used the local pubs and shops. I'm not into churches."

### Daily Life

"I didn't do any sort of work that I got paid for. I didn't go to any Day Centres, I wasn't interested in them because I didn't want to be used."

"I would go out every day because I was being totally used in the project. In the evenings I would go out too. If I had money I would spend it in the pub. I watched television on Saturday for the sport, the football. I did

watch quite a lot of television in the project. I watch a lot of sport, I don't do any myself but I am fit. I read the Daily papers every day. I sometimes liked talking to the other residents but they were lost with themselves, out of touch."

Adrian never went away for a weekend or on holiday while he was living in the project.

"I havn't been on holiday for years. It would be nice to get away from the city from all the pollution, to go to the coast for the day to get some fresh air."

Adrian had never heard of the IMHF.

*Adrian would hang around the house on an average day. He did not seem to have any interests apart from the pub, and did not seem to want help in channelling his attention into anything. He often helped another resident, Brenda, who was frail, with her shopping and she would give him money for helping.*

#### Finances

"The Social Security gave me money in the project. I had Housing Benefit but I had to pay five or ten pounds out of my own money towards the rent. It was forty pounds. I had problems with the DSS because my giros got stolen a few times out of my personal letter box. I got back from the pub one day a bit drunk and all the boxes had been busted and broken into. I spent most of my money on being sociable."

### Medication

"I've been off medication for four years. When I moved into the project, I thought I must give up the medication. I told Dr Robertson and she said all right. It was very hard to give up because it was addictive and I was in a room on my own, but I managed."

### Professional Contacts

"I saw a social worker regularly but not any members of the Transitional Team or the Community Mental Health Resource Team. I had a GP, Dr Ali. I saw Dr Robertson a lot and got on very well with her. I think she is a very good person. I was surprised that she had a baby. I also got on well with the social worker and my GP."

*Adrian had very little contact with professionals while living in the project. He did not want to have anything to do with the Community Mental Health Resource Team.*

"When I had a problem in the project, I told the housing workers, but they were no help at all. They could give you a hard time. When I asked Simon if I could use the telephone to ring the DSS to sort out a problem, he said I couldn't, even when I offered to pay the 10 pence. Alison was a black woman and she could also be a problem. Arthur was quite nice. He was very clever and would always take time to listen to your problems. I think he was a homosexual."

### Social Network

*Adrian did not mention, or have any contact with, his family while living in the project.*

"I knew people in the area around the project. I wouldn't call them friends, they just wanted money."

#### Leaving the Project

"I had been on the list for a council flat for three years and I got this one at the same time as I was evicted from the project. I had an argument with the Manager, Cecilia, about punching Aaron, another resident. That is why I was evicted. I couldn't take Aaron any more. He is a black man about seven feet tall and he is cunning. I couldn't stand him. He interfered with me when I went in the kitchen. He was always there. He had never read a newspaper. If it hadn't been for him, I would probably still be there."

"I've been banned from the project now. After I left I went back to see the other residents. I slept on Bertha's floor for three nights on the floor. That is why I was banned. I thought that was wrong. It is her room, she pays the rent for it and they are allowed to have friends to stay."

*Adrian pushed the other residents in the project around. He was a bully and threatened them. It was this that led to his eviction, although he was not evicted until he had somewhere else to live. The project workers had become increasingly concerned about his sexist and racist behaviour. He also began to have problems with neighbours because of noise and disturbance and he had punch-ups in the pub. Before he was evicted, he physically assaulted two residents. One of them became very distressed as a result.*

*The project staff saw Adrian for about three months after he left, first weekly, then at longer intervals. He continued to return to the project and created tension in the house by asking the vulnerable residents for money, requests they could not resist. As a result, the project workers wrote to Adrian to tell him that he had been banned from the house. One of the residents, Bertha, visits Adrian but it was a long time before he allowed her to come to his flat.*

#### IN THE COMMUNITY - LIVING INDEPENDENTLY

"I am completely independent in the flat. I like this flat because it is my own place. It's a council tenancy. I'm not worried about the neighbours even if they do ignore me. I've decorated the flat myself but I don't have a cooker yet. I have a key meter for the electricity. I manage to budget for rent and bills better with this.

I like the Caledonian area better than the area around the project. It's a bit rough and noisy but I like it better. The neighbours are still the same but I don't look for trouble. I use the local shops but the Lion at Archway is my local pub. I still go out every day.

I go to Hanley Road Day Centre now. It is great. I know Cathy and Mabel well. I work there on the Reception. I only get paid two pounds an hour but it is extra money. I havn't been for a couple of weeks. I sort of lost interest but they do help me to help myself there.

I don't watch so much TV now. I have a music centre and a lot of tapes so I listen to a lot of music.

I still have the same GP. I thought he wouldn't take me any more because I had moved to Caledonian Road. I looked around for another GP but I was pleased that Dr Ali kept me. I don't need him for medication, just for sick notes, if I'm not well for the DSS.

I felt much better when I moved into the project but now I still get blackouts. That's why I wear the dark glasses. I don't see Dr Robertson now because I have no reason to and I don't have a social worker any more. I see Susan Brown from the Community Mental Health Resource Team. I was supposed to meet her last week and I forgot. She wrote to me. I think she is worried about me. All those people, they just sit and drink tea and I am finished with all that.

Financially, I manage. Well, I survive. I need more money but it wouldn't matter how much more I got, I would spend it. I spend most of my money on rent and I'm paying-off sixty pounds rent arrears at two pounds a week. These rent arrears came about because it was eight weeks after moving before I got Housing Benefit. I agreed with the Estate Manager to pay them off which I thought was OK. I pay twenty-seven pounds a fortnight.

If I have a problem now, I sort it out myself."

*It is now the responsibility of Susan Brown of the Community Mental Health Resource Team to monitor Adrian's progress. However, he has proved very difficult to keep in touch with. She has only seen him four times, despite endless letters. At first, he seemed friendly and pleased to see her, but once he received his Community Care Grant,*



it was as if he did not want to know. This may be because he thought he was used in hospital by the doctors, and now he thinks he is justifying the jobs of other professionals.

Adrian took a lot of things to his new flat from the project and got a Community Care Grant of five hundred and fifty pounds. He needed a cooker and fridge but he said he wanted new things. He ended up blowing the money on drinking and betting. He says he does not mind now about the cooker and fridge because he eats out.

Susan was able to keep in contact with him, informally, when he was attending the Hanley Road Day Centre, but he stopped going. She was very worried about him at that time because he seemed to be becoming very disturbed. He thought the neighbours were trying to kill him. The next-door neighbour complained about him very soon after he moved in because he was always hammering on her door. When Adrian becomes disturbed, he wears dark glasses and is obsessed with witchcraft, demonology, and the IRA. He speaks endlessly about sacrifice and is very frightened. He often has black eyes, a sign that he has been fighting.

If anything was very wrong with Adrian, Susan would hear from the Estate Manager, or through Bertha and Brenda from the project, or through Hanley Road because he has started attending again. It is very difficult for her to give him support and, at the same time, not be obtrusive because he is a very private person. Basically, he is very lonely and isolated. All he likes doing is going to the pub and he may be looking for a girlfriend. Susan's greatest worry is that he ends up in prison, or compulsorily detained

*in hospital because of violence, to others or that he has attracted to himself. All she can hope is that he knows where she is and that he will make contact.*

#### Life in the Community v. Life in Hospital

"Looking back now Friern was terrible, like a nightmare, but I've forgotten about it now."

"I think some of the patients will be sick for the rest of their lives but I think I am all right because I will never say die. You have to be nice to yourself. I am nice to myself because I keep myself clean and tidy."

"I wanted to talk to you, not just for the money, but because it is good to speak about what has happened. I wanted to talk about my experience."

#### Researcher's Observations

When the researcher arrived at Adrian's flat, a neighbour came out on to the landing and watched her go in. This was repeated when she left the flat after the interview.

Bertha, a resident of the project Adrian had lived in, was in the flat when she arrived for the interview. He told her she would have to leave because 'we are going to have a chat'.

Adrian was well-dressed, friendly, and took pride in showing the researcher around his flat which was clean, tidy, and homely, although lacking a cooker. Adrian was wearing dark glasses for the first ten minutes of the interview and put them on and off during the interview. Throughout the interview there was anger in Adrian's voice

which made the researcher feel uncomfortable and sometimes frightened.

After the interview was finished, Adrian became more relaxed, removed his dark glasses and, after receiving the money for participating which he was very pleased to receive, began speaking to the researcher in a conspiratorial manner - us against them, all the people who had used him. He said he had enjoyed the interview and would be happy to be interviewed again without being paid. He asked questions about the research and said he would be very interested to read about it. On showing the researcher out of his flat, Adrian put on his dark glasses again.

#### Conclusions and Recommendations

Adrian's schizophrenia seemed to have emerged after a stressful life event (finding a dead body), at a time when he was living on his own and working in a depressing environment. However, his obsession with witchcraft, demonology, the IRA, and his paranoia about neighbours watching him and plotting to kill him may, in view of his Irish background and because he made no mention at all of his family, indicate some sort of prior threatening connection with the IRA which could also be a precipitating factor.

Adrian generally regarded his life in hospital to have been a very negative experience. He was clearly aware of how run-down the hospital was and of the negative effect of the institutional environment. He felt that his stay in hospital was an unjustified punishment since he could not

help being ill. However, he did not think that he was seriously mentally ill, he merely had some understandable problems for which he should have been given counselling. Instead, the hospital doctors used him to try out drugs and he, consequently, became addicted to medication.

This perception of being used by hospital doctors seemed to have become generalised to nearly all the other professionals Adrian had come in contact with, although he did acknowledge that he was only able to leave the hospital because of the support of the project workers who first visited him there. As a result of Adrian's determination not to be used to justify the positions of professionals, he tended to turn down, or ignore, their offers of support.

Adrian's story could be described as a 'success' of community care because he was a young man who could have remained in Friern for the rest of his life if it had not been for the hospital's closure programme. After a year in the community, he was no longer on medication and after three years, he had moved from supported accommodation to independent living. Adrian, himself, clearly regarded this as progress and he attributed this progress to his own strength of character. Given his attitude to professionals, the researcher agreed that Adrian had reached his present position largely by his own efforts and that he had achieved much. However, Adrian had some serious and long-standing problems which had not been resolved and which could change the interpretation of his story from a success to a failure.

Adrian voiced racist and sexist attitudes, he did not seem to want to be associated with people with mental health

problems and appeared intolerant of them, and he had a propensity for violence. All this seems to have negatively influenced how Adrian had perceived and reacted to the residents and workers in the project, and all the neighbours and professionals he had come in contact with, and often how he, in turn, had been perceived and treated by them. His move from the project to independent living cannot be viewed as progress when it is noted that he was evicted from the project for assaulting two residents, after increasingly being involved in trouble with residents, neighbours, and the wider community. Also, he seemed to have the same problems living independently as he had had in the project.

Adrian had not had any structure to his daily life, either in the project or since living independently. Paid work at a Day Centre was not even a big enough incentive for him to attend regularly. He had a weak social network in that he only had casual acquaintances and he seemed to be more lonely and isolated since being banned from the project. This appeared to have accentuated his obsessions and paranoia which had caused him further problems, as seen in his blackouts, wearing of dark glasses, and the outward signs that he had been involved in fights.

Adrian clearly needed professional support if he was to avoid being evicted again, or come to the attention of the authorities because of violence to himself or others. In view of his negative attitude to those available to help him, however, the professional responsible for monitoring his progress had found it extremely difficult to offer him

support even with practical matters such as managing his community care grant, without being intrusive.

The 'treatment' Adrian received in hospital did not seem to have helped him, so perhaps he was right when he said he needed counselling to overcome his problems. Adrian did seem, to the researcher, to be the sort of person who would respond well to this sort of therapy, however, he would probably now consider a counsellor to be just another professional.

Adrian said that he had forgotten about the nightmare of the hospital, but the researcher concluded that this could be a reality again for Adrian if he went to prison or became compulsorily detained in hospital. She would, therefore, recommend that Adrian be deceived into accepting some professional support by disguising the professional as a person who wants to talk to him, over a period of time, about his experiences so that he/she may be able to help others who have had similar experiences, thus placing Adrian in a more equal or powerful position so that he does not feel used.

## FINAL CONCLUSIONS AND RECOMMENDATIONS

### Biographical and Standard Information

A Table of biographical and standard information on the ten Islington ex-long-stay patients interviewed is contained in *Appendix 10.1*. In summary, three women and seven men were interviewed, and they had all been diagnosed as suffering from schizophrenia. Their ages ranged from 33 to 67, nine

were single, and four were from minority ethnic groups. Their length of stay in Friern ranged from one year to 40 years, and their length of time in the community ranged from ten months to three and a half years. The researcher, therefore, concluded that there was a predominance of younger single men who had not been very long-stay in hospital, and also a high number of people from minority ethnic groups, in this small group who all suffered from schizophrenia.

### Illness

Before being admitted to hospital, four people had been living alone and may have been socially isolated. Two of these mentioned experiencing stressful life events and social problems prior to the onset of illness. Five people had been living with family before being admitted to hospital. Two of them had unhealthy family relationships and two had experienced stressful life events connected with the family prior to the onset of illness. The researcher, therefore, concluded that there was evidence in these accounts to substantiate the Environmental Theories of Schizophrenia which were discussed in Chapter 5 (p158-162).

### The Hospital and Hospital Staff

When initially questioned about the hospital, people expressed a diversity of feelings. Four said it was 'all right', three said life in hospital was 'terrible', one described life in hospital as 'gloomy and boring', and two expressed mixed feelings - one said it was 'normal' but

'tormenting', the other that he liked the hospital but did not want to go back.

Feelings about the hospital, looking back, were generally negative. One person said they felt bitter about the hospital, two people said they wanted to forget about the hospital, four people said they did not want to go back, one person said that they were frightened of going back, and two people said that although they still felt 'all right' about the hospital, they did not want to go back to live. However, five people had visited the hospital since leaving and one admitted suppressing a desire a visit.

The researcher suspected that the ambiguity in expressing negative feelings about the hospital but continuing to visit may have been because the majority had spent a very short time in the community compared with the time they had spent in hospital. This meant that, although they no longer wanted to live in the hospital, they liked to see familiar surroundings and faces.

The things people mentioned as liking about the hospital could broadly be described as 'work and social activities': having more money; paid work; discos; trips to the seaside; friendly people; and, the cafe.

Only two people made any negative comments about hospital staff - one liked hospital staff but felt 'used' by doctors, the other said that some staff were bad. Otherwise, comments about staff ranged from 'all right' to admitting they liked and got on well with staff, and turned to them with problems. The researcher, therefore concluded that the overall response to hospital staff was positive.



Length of Hospital Stay : Feelings about Closure and Leaving

The table below lists the people interviewed in order of length of hospital stay (beginning with the shortest) and their feelings about hospital closure and leaving. This

Name	Length of Stay in Friern (yrs)	Feelings about hospital closure and leaving
Bernadette	1	much cheerier when told hospital closing, overjoyed about leaving
Alan	2	surprised about hospital closure, glad to leave
Albert	2	sad at first about closure and leaving, then got used to it and looked forward to being independent
Adam	4	felt terrible when told hospital going to close and terrible about leaving
Adrian	5	worried about hospital closure and worried about leaving, didn't want to leave
Alexander	6	crying when told hospital to close, didn't feel happy about leaving
Belinda	6	said they couldn't have me back because hospital was closing, felt all right about leaving (NB. 2nd time)
Andrew	14	regretted the hospital closure because he liked to visit there but glad to leave
Archie	24	is the hospital going to close? felt OK about leaving
Bronwen	40	felt a kind of relief about hospital closure, horrible about leaving but pleased at the same time because I'd be on my own again

shows that there was a tendency for those who had only been in hospital for two years or less, and those who had been in hospital for many years to feel more positively about hospital closure and leaving, than those who were 'medium' long-stay. The researcher concluded this may be because: those who had only been in hospital for a shorter time were neither so institutionalised nor so anxious about returning to the community and re-learning the necessary skills as the 'medium' long-stay; and, at the other end of the scale, the very long-stay patients had become so institutionalised that they had become resigned to their fate, and they had nothing to lose by starting again. Also, they were probably less anxious about moving to the community because they had no memory of life outside the hospital and, after many years of neglect, they had suddenly become the recipients of a great deal of attention.

There was a tendency for those who felt negatively about hospital closure (eg. sadness, worry, terror) to retain the same negative feeling about leaving, and for those who felt positively about closure (eg. cheerful, relief) to adopt a positive attitude to leaving. The shock and feeling of instability caused by the Hospital Fire in 1988 seemed to make those who felt negatively about the hospital closure more amenable to leaving.

### The Community

Everyone interviewed said they liked living in their particular project in the community and the area in which they lived. Three people said their lives were positively

different in the community, four people said they liked the freedom and independence of life in the community, two said they liked the people where they lived, and one said that their life was no different in the community. The researcher, therefore, concluded that the general feeling about living in the community was positive.

Eight of the people interviewed had originally come from Islington and five of them were living in projects in an area which they had lived in, or nearby, before. Therefore, they were returning to the 'community' from whence they came. Since the majority seemed to have made good progress in the community, the researcher felt that perceived familiarity with the area appeared to have had a positive effect on their adaptation to living in the community.

Only one person made little use of places in their immediate area because of a physical disability. The majority made good use of places in the wider community. However, they seemed to have little contact with people in the community. The majority said that they had no contact at all with their neighbours, and one person had experienced serious problems with neighbours. The researcher thought that six people were likely to be noticeable in the community because of shouting, odd posturing, aggression, and strange appearance. However, only two appeared to have attracted hostility from people in the community. She, therefore, believed that the people interviewed, like their counterparts in the Pilot Study, had neither been accepted nor rejected by neighbours or people in the wider community.

### Work and Social Activities

Eight people mentioned that they had worked before being admitted to hospital and paid work was something that people mentioned as liking about the hospital. All ten had engaged in regular, mostly full-time, work in hospital whereas only four people had paid work in the community and this was only for a few hours at the most each week. Only three people were attending Day Centres on a regular full-time basis. Five people attended Centres part-time and two people did not attend any organised day-time activities because they had found them unsatisfactory. Nobody was attending mainstream community activities such as those taking place in Adult Education Institutes.

The researcher noted that, in the absence of the opportunity for regular full-time paid work, there was no conventional distinction between the work and leisure time of the people interviewed and long periods were spent in the rather solitary, unproductive, but inexpensive pursuit of watching television - also a feature of hospital life.

Social activities were something else that people had mentioned as liking about the hospital and desiring in the community. By virtue of the large numbers of people living in hospital, it was possible to organise these cheaply on a regular basis. In the community, however, people were living in very small groups and, consequently, it was too expensive to organise regular social activities on a project basis. There also appeared to be a lack of larger-scale social events at conventional leisure times in the community.

The researcher, therefore, concluded that the people interviewed did not enjoy the same opportunities to engage in paid work and social activities in the community as they had in the hospital. Paid work can strongly motivate people to adhere to a structured day, increase their self-esteem, engender independence, as well as relieve financial hardship. Organised social activities give people the opportunity to practice social skills and broaden their social network. Therefore, the absence of sheltered work schemes and organised social events in the community were an impediment to people learning or re-learning the skills necessary to engage in mainstream community activities.

If integration in the community is an aim of community care then work schemes and leisure facilities should not be lagging behind residential projects, both in their planning and implementation. If they are, then people leaving hospital may feel that they have 'lost out' by moving to the community, and their progress may be impeded.

### Finances

After paying for their accommodation and food, the majority of the people interviewed had very little money left to spend - just over one pound a day was the norm. Five people spent most of their money on cigarettes, which was understandable given the price of tobacco and the observation that it was neither as easy, nor as acceptable, to 'cadge' cigarettes in the community as it had been in the hospital, the place where smoking had at one time been

actively encouraged. Betting, clothes, alcohol, and sweets were the other consumers of their scant financial resources.

Only four people said that they were able to manage on the money they received. This seemed to be because they had financial support from their family, some paid work, a small amount of savings, or did not smoke. Three of the remaining six were paying-off rent arrears, and everyone interviewed was extremely grateful to receive five pounds for participating in the research. The researcher, therefore, concluded that the majority were suffering from financial hardship.

It could be argued that they shared this plight with other people in Britain living on Benefits. However, the majority of long-stay patients come to the community with nothing. They have little or no material possessions to sell or savings to draw on, in times of need, and they lack the self-confidence and skills to find and undertake casual 'cash-in-hand' work which, if undeclared, means they do not lose their entitlement to benefits. Due to the shortage of sheltered work schemes which allow people to earn a small amount of money without affecting their benefits, the researcher concluded that the ex-long-stay patients were more financially disadvantaged than other people receiving Benefits.

Financial hardship makes it difficult, if not impossible, for people to participate in mainstream social activities in the community such as going to the pub or cinema. The researcher concluded that this was more of a disadvantage for ex-long-stay patients than, for example,

the long-term unemployed since the latter are settled in the community and have an established social network. In contrast, the ex-long-stay patients are trying to become part of a new community, and build-up a new social network. She, therefore further concluded that financial hardship was another impediment to ex-long-stay patients becoming integrated in the community, although this was connected to lack of opportunities to undertake paid work, a situation which could be remedied.

### Social Network

The majority of people interviewed had a small social network of family and friends. With regard to family, three people had no contact, three had occasional contact, and four had regular contact with their families. However, two of the people who had family contact had an unhealthy relationship with their family, so this contact was unlikely to have been emotionally beneficial. Only three of the people interviewed seemed to have friends who were people other than those they lived with or had known in hospital. The researcher, therefore, concluded that the majority could benefit from being part of a Befriending Scheme, especially when they first left hospital and if they were, or became, physically frail since this would make it more difficult for them to meet and communicate with people in the wider community.

Only one person had been to meetings of the IMHF. Two people said that they had heard of the Forum and three gave the impression that they did not want to be associated with

people with mental health problems. In view of the Forum's aims and the composition of its membership, the researcher concluded that everyone interviewed could benefit from attending the Forum's meetings. These meetings would give them the opportunity to talk about and share their problems, voice their opinions and grievances, expand their social network, and increase their self-confidence by exorcising the stigma attached to mental illness.

### Support in the Community

The majority of people interviewed tended to rely on their immediate carers in the community for day-to-day practical support and to sort out problems when they arose, as had the people in the Pilot Study. However, the Islington ex-long-stay patients differed from those in the Pilot Study in that they also had additional support, especially when they first moved to the community, from at least four of the following professionals: community psychiatrist; social worker; CPN; member of TT; member of CMHRT; and, GP. The frequency of contact with these professionals seemed to have been determined by their needs but tended to become less the longer they had been in the community.

The researcher, therefore, suspected that the Islington ex-long-stay patients were not so reliant on a particular individual as those in the Pilot Study and consequently they would not be so adversely affected if that person was no longer there. This was of particular importance in projects with a high staff turnover. The difference between the Islington ex-long-stay patients and those in the Pilot Study



with regard to support in the community reflected the different arrangements made by the health authorities involved in the Friern closure programme for evacuating the hospital and providing alternative services in their respective communities. The researcher, therefore, concluded that there was no 'equality of care' in the community for long-stay patients leaving the same hospital.

The majority of Islington ex-long-stay patients mentioned 'liking' their Community Psychiatrists, probably because they had known them in hospital as Friern Consultants. Some people, however, seemed confused about who they had seen from the TT and CMHRT, and also questioned the absence of, or appeared to miss contact with, these people. The researcher, therefore, concluded that there was a need for consistency in this more 'informal' level of support, but that this would be difficult to achieve given the specific roles of these Teams.

### Progress in the Community

The people interviewed had experienced a wide range of problems in the community with, for example: finding a GP; receiving DSS and other financial entitlements; budgeting; medication; personal safety; and, family interference. The researcher noted that those in the Pilot Study had experienced the same problems. Also, two people had had previous placements which had proved unsuitable, and two people had had to return to hospital for short stays when their particular problems aggravated their mental state to

such an extent that they could no longer be properly cared for in the community.

The researcher, therefore, concluded that when people returned to hospital it may have had a negative effect on both those returning and those still waiting to leave, and that there would be a need for hospital beds for ex-long-stay patients in the future when Friern had finally closed. Given the number of other people with mental health problems to be cared for in the community, the researcher further concluded that the Whittington Psychiatric Wing would be unable to cope with the demand for hospital care in Islington.

It would have been unrealistic to expect long-stay patients to make a totally smooth transition to living in the community, partly because of the difference in the hospital and community living environments which was discussed with reference to the people in the Pilot Study. However, the researcher concluded that some problems arose because of inadequacies and oversights in the assessment, selection, and preparation procedures which could ultimately be attributed to weakness and failure in the planning process.

She believed that this was because planners and providers of care in Islington were expected to begin evacuating the hospital, and to deliver alternative services in the community before they had: gathered all available information on the people they were moving to find out what their requirements would be; discussed the problems they may face and introduced measures to counteract these; considered

what additional staff would be required to implement the closure programme, what their responsibilities would be, when they should be appointed, and how to amalgamate them with existing hospital staff; discussed and established the terms of reference and operational definitions for various groups working on the closure programme, and devised a timetable for closure which would ensure the smoothest possible transition from hospital to community. She further concluded that this was because NETRHA had put pressure on local planners and providers to empty the hospital as quickly as possible so that they could avoid the huge cost of maintaining the hospital and promptly capitalise on the high value of the Friern site.

Despite the afore-mentioned problems, the researcher concluded that the majority of people interviewed had made good progress in the community; one person was living completely unsupported; two people occasionally needed a minimum level of administrative or emotional support; five people still required a constant but minimum level of administrative, emotional, and housing support; one person needed only minimum administrative and emotional support but intensive housing support because of a physical disability; and, another required constant and intensive administrative and housing support because of age, vulnerability, and long-term institutionalisation.

One person had moved on to completely independent living, but there was a possibility of his success turning to failure if he came in contact with the prison services. It was anticipated that five more people would be able to

move onto more independent living, in time, but one of these was removed from a project in the community by his family and re-hospitalised, thus arresting his progress. The remaining four would probably not be able to move on because of age and vulnerability, physical frailty, violent episodes, and the need for a supported environment. She, therefore, concluded that there would not be many vacancies in the projects in which they were living in the near future. Thus, there would be few places to offer people who would suffer from mental health problems in the future and need to be cared for in a supported environment after Friern had finally closed.

Since it seemed unlikely that many of the people interviewed would have left the hospital if it had not been for the closure programme, the researcher concluded that the decision to close Friern had ultimately been to the benefit of the long-stay patients. However, given the progress they had made, she further concluded that some of those who could be termed the 'successes' of community care would never have become long-stay if they had previously been the subject of intensive rehabilitation and there had been somewhere to discharge them to. Further, the problems experienced by ex-long-stay patients, which arose as a result of the emphasis placed on financial considerations, had human consequences in that their transition from hospital to community was perhaps not as smooth as it could have been.

The researcher concluded that the care of Friern patients who were not part of the closure programme such as acute short-stay, 'revolving-door', those who had not had a

year's continuous admission, and Islington residents who would suffer from mental health problems in the future was uncertain when Friern finally closed. This was because Friern was an institution which, despite all its negative aspects, had the capacity to deal with large numbers of people whereas the Whittington Psychiatric Wing could only cater for a very small number in comparison. Since it was likely that the other health districts Friern had served would face a similar bed crisis, it was to be expected that North London would be confronted with a mass of disturbed and disturbing individuals, showing visible signs of neglect, wandering the streets and sleeping rough. This situation would probably make communities less tolerant of people with mental health problems and less inclined to support the policy of caring for them in the community.

### Recommendations

With regard to the closure of large hospitals such as Friern, the researcher would 'ideally' recommend the following:

- (a) An initial assessment of the needs of long-stay patients should take place before potential managers of residential projects decide what level of support and philosophy of care they will offer.
- (b) Patients' opinions with regard to moving to the community should, where possible, be honoured and they should be represented at selection meetings.
- (c) There should be a clear policy on issues such as medication, and set of procedures for claiming DSS and other

entitlements before patients leave the hospital to ensure 'equality' in their care in the community.

(d) A Case Coordination system should be set up before long-stay patients leave the hospital and their progress should be regularly monitored in the community.

(e) An amalgamation of hospital and community-based staff should prepare long-stay patients for the move to the community and each patient should have a keyworker in this group of professionals who will maintain regular contact with them when they first leave the hospital.

(f) In communities targeted to receive long-stay patients, there should be education programmes to alert GPs, in particular, and the public in general, to the problems suffered by these 'newcomers' and the sort of environment that may help them to adapt to life in the community.

(g) Residential project staff and other key professionals should be employed on fixed-term contracts.

(h) Long-stay patients should be given the opportunity to engage in sheltered work schemes which will allow them to earn some money without affecting their entitlement to benefits, and to attend Day Centres, at the same time as they move into residential projects.

(i) Long-stay patients should be matched with Befrienders very soon after they move to the community.

(j) Subsidised large-scale social events at evenings and weekends, for example, a Saturday night disco, Wednesday evening social club, and Sunday games afternoon on a rota basis at different Day Centres, should be organised, and

long-stay patients should be able to attend these very soon after moving into the community.

(k) Long-stay patients should be actively encouraged to attend groups like the IMHF and, once they have become more settled in the community, to take part in mainstream community activities.

(l) Part of the old hospital site should be used to build a small hospital to cater for people with mental health problems which the District General Hospitals cannot accommodate.

(m) A few short-stay projects should be set up in the community to accommodate and support patients who were not part of the closure programme, or people who may suffer from mental health problems in the future, in times of crisis.

## C H A P T E R 11

### OTHER FRIERN EX-PATIENTS

#### INTRODUCTION

This Chapter is concerned with the experience of the eight ex-patients of Friern Hospital who were interviewed by the researcher at the LBI Day Centre, The Avenue, in June and July 1992.

Although interviews with these people began with questions on The Avenue and ended with questions on Friern Hospital, she has presented the individual accounts of their experiences in roughly the same order as those of the ex-long-stay patients, to give continuity to the narratives. However, there is no specific section comparing their life in the community with life in the hospital, and a section on their life pre-hospital has only been included when they specifically mentioned this - in general, information on this subject tends to appear in other sections.

The individual accounts of these eight people are completely 'in their own words' because the researcher had no prior knowledge of them and nobody else was interviewed about them. Her observations and conclusions follow each individual account.

To protect their anonymity, she has given these men and women fictional names beginning with the letters C and D, respectively. As with the accounts of ex-long-stay patients, people mentioned by them have also been given fictional names, but places have retained their real names.

This Chapter ends with a summary of the information in the individual accounts and the researcher's final



conclusions and recommendations. Where appropriate, comparisons have been made with the experience of the ex-long-stay patients.

## C A R L

### Background

Carl was a 64 year old, single, German Jew. He had been a long-stay patient just before the Friern closure programme began.

### Life Pre-Hospital

Before going into Friern, I lived in a Jewish hostel for people with mental health problems in Mercer Gardens in Hampstead.

### Life in Hospital

I was in Friern for 24 years, then in April 1978 I was moved to the Whittington. I was there for 6 years until 8th June 1984 when I moved to Adam House.

It's a very difficult question to answer about my relationship with the staff. Some I liked a lot but some staff were bad.

I went to the South Workshop a lot. I supervised mops. I didn't mind my life in Friern but I was never really well. If I hadn't been so ill, I could have enjoyed it a lot. The Whittington was not too bad but there were long queues for dinner. Again I was too ill to enjoy it as much as I could have.

I've heard Friern is going to close. When exactly will that be? I think it is bad because the patients will have nowhere to go.

### Domestic Life

I live in a hostel in Palmers Green, Adam House. I have lived there since 8th June 1984. I remember that date very clearly. I have a room for two people. They do the cooking for me and a woman comes to clean. I like living there but I have been in trouble with the Manager who is a fascist and a martian. Don't tell him what I said. Don't you know anything about Mars? Have you been to other countries in Europe?

### Daily Life

I have been coming to The Avenue since it opened on 1st October. I don't remember the year. Before I was at Finsbury Town Hall.

I come every day except Thursday when it is closed so I come four days a week. I usually arrive at 11.00 am or a bit before. I was late this morning. I stay until about 4.00 pm. I have to leave then to get back to my hostel in Palmers Green for tea. It can take a long time to get back, sometimes an hour. They want me back in the hostel for tea. I have to go back because I don't want to miss supper.

I don't do very much at the Centre now. I play Mastermind with my lady friend. I have other friends, male friends but I spend most of my time with Dorothy Black. I like the Centre although sometimes I don't like the food, but mostly I like it.

I used to go somewhere for woodwork. There were teachers and I liked it very much but the building caught fire, it was a Saturday, didn't you hear about it? I would definitely go to woodwork if they did it here.

I couldn't come to the Centre if it was open at any other times because I have to travel from Palmers Green but I wouldn't want to come at other times. I don't go anywhere else. I did go to Pine Street when the cafeteria was being built here because the whole building had to be rebuilt. I just went there temporarily. The people were very nice.

I don't do much at the weekend. I haven't been on holiday or away anywhere in the last two years. I don't really like going away anywhere.

I watch a fair amount of television. Some programmes are good and others are not. I have never read a book, not because I'm illiterate but because it's beyond me. It's because of my illness that I can't concentrate. I read newspapers and magazines though. I watch football and other sport on television. The Scotland and Germany match is on this afternoon. I will have to want Germany to win.

#### Community Life

I don't mind Palmers Green. I have absolutely nothing to do with the neighbours at Adam House. I never go to pubs. I use the local shops. I would go to a synagogue if there was one. I don't go to the cinema because it is very expensive and everyone can see films on television now.

### Finances

I have six hundred and thirty one pounds in the savings bank. I asked for fifteen pounds a week instead of ten. I needed the increase but he said that if I wanted it I would have to take it out of the savings bank money. The Solicitor knew about the money and had sorted out the Court of Protection. I spend most of my money on cigarettes but I do buy other things.

### Social Network

The only family I have is a brother, a twin brother who lives in Israel. He is married with children. (Carl shrugged his shoulders) He has visited me five times.

I mostly meet friends at the Centre, especially my lady friend.

### Professional Contacts

I have a social worker called Suzanne. My GP is Dr Ali.

When the researcher asked Carl about what he did when he had problems, he said 'What sort of problems?' When she said, for example, problems with money or, if he wasn't feeling well, he said:

I have nobody to tell about my problems, everybody else here is too ill here to help with your problems.

### Researcher's Comments

Carl was smartly dressed and well-spoken. He looked a lot younger than his 64 years. The Centre worker who had arranged the interview said that Carl was initially a bit

anxious about talking to a researcher because he had been in Friern for such a long time. He seemed worried that he was five minutes late for the interview, and had to be reassured that she had nothing to do with Friern Hospital or Social Services, and that everything he said would be confidential, before the interview could begin. He then seemed to be quite happy about being interviewed.

At the end of the interview, Carl asked about the research and wanted to know how many people at the Centre the researcher would be talking to. He mentioned the names of some of his friends, including his girlfriend, at the Centre and asked if they would be interviewed. He said that he thought five pounds was a lot of money for what had been expected of him, and did not seem to want the meeting to end.

### Conclusions

From the dates supplied by Carl, he was admitted to Friern Hospital in 1954, but he had previously been living in a Jewish Hospital for people with mental health problems. The researcher concluded that his illness may have arisen as a result of his experiences in Nazi Germany. This would explain why he associated Mars with a country in Europe, a Martian with the 'fascist' Manager of the Hostel, and was anxious about people in authority.

Since being admitted to Friern, Carl had been the responsibility of three different health authorities - Hampstead, Islington, then Haringey. The researcher,

therefore, concluded that there had been little continuity in his care.

When Carl moved to the Whittington, he began attending The Avenue, and when he was discharged to a Hostel in Haringey, he spent 2 hours a day, four days a week travelling to Islington to attend The Avenue because it was a place he liked and where he had friends. This may explain why Carl had little to say about the area in which his Hostel was situated and why he did not consider the Hostel to be his 'home', even though he had been there for eight years. The researcher, therefore, concluded that there was little continuity between Carl's home life and daily life, and that the long journey to the Centre could become problematic for Carl as he got older. However, if he was unable to attend The Avenue, he could become very socially isolated.

As a long-stay patient of first Friern and then the Whittington, Carl would have been part of Islington's closure programme if he had not been discharged before it began. The researcher concluded that Carl would have benefited from being part of the closure programme because he would have been discharged to a residential project in Islington which would have been a more 'homely' environment than his Hostel, and from which he could have travelled much more easily to The Avenue. He would also have had considerable professional support and, therefore, people to talk to about his problems, and to help him become more independent with regard to daily living skills.

Carl did not seem to regard his time in hospital as a negative experience, although he clearly remembered the date he was discharged. Also, he did not think that Friern should close, out of concern for what would happen to the patients.

## D O R E E N

### Background

Doreen was 60 years old, divorced, with children. She had been long-stay in the Halliwick Wing and had had four short-stays in Friern before the closure programme began.

### Life in Hospital

I had a breakdown in 1973 and spent two years in Halliwick. I quite liked it there and didn't really want to leave. I can see the reasons for my breakdown now. My husband's drinking and I had a son who was not right. He is a vegetable now. He was taken away at birth. I haven't seen him for a long time. I ought to write. I had another baby son who died and then they sterilised me at 26. My daughters were all right. It was a genetic disorder, something to do with rhesus blood. My husband and I were not compatible. While I was ill, my husband went off with his brother's wife. His brother had died. Now they live near me which is uncomfortable. My daughters were good when I was ill. One of them got me into a hostel but a social worker saw that I wasn't coping and got me into hospital.

I was in and out of Friern four times for about 6-7 weeks each time. I also spent some time in the Royal Free and then I attended the Whittington Day Hospital for 5 months for therapy. That helped me to realise things about myself. I havn't been in Friern since 1982.

I have bad memories of Friern. It was depressing, it was as if I was a different person. Some of the staff were nasty and there were some bad incidents. Although I was ill, these incidents were real, I was not fantasizing. I did once go to a Day-time Workshop but I didn't like it and it was like slave labour.

I didn't know Friern was going to close. I feel sad for the people who need somewhere like that when they are ill because otherwise the burden will fall on their families. I was separated when I was ill again and my daughter took me in, but it was unfair for her to have to look after me. I needed to be in hospital and I liked the Halliwick. I think it would be better to have a smaller hospital for people to go to when they are ill.

#### Domestic Life

I live on the council estate in Essex Road. I've been living there for nine years on my own. I like the place and I do my own cooking, cleaning, and laundry. My daughter helps with shopping twice a week and the gardening.

#### Daily Life

I used to go to the Finsbury Town Hall Centre. I went to Pine Street for a while to the Women's Group but had to stop because I had a bad leg. It was swollen. I've been coming



to the Creative Writing Group at The Avenue for a couple of months. I usually come to The Avenue once or a couple of times a week.

I like the Creative Writing Group here and the Canteen. There seems to be different staff running it now. The first time I came to The Avenue, there were drama, art, music and movement groups. It was more like a college then and I enjoyed it. The only thing I don't like about The Avenue is that there are a lot of people sitting around doing nothing. There's nothing I'd like to do at The Avenue that isn't available and there are no extra times that I'd like it to be open. It is open til 8.00 pm some days and sometimes on a Sunday.

I don't do any work. I don't go to therapy at the moment. I'm on medication. My problem is obsessive, compulsive behaviour. It's been worse at the moment. That is why the doctor has given me medication and I had a nurse for a week. It is very stressful. I have to do everything before I come out. It was very difficult for me to come today and the medication is not helping. My mouth is very dry. (The researcher gave Doreen a sweet)

I spend about two evenings alone. One of my two daughters come on the other evenings. I spend a lot of time in the garden in the summer. I don't have a lot of friends. On Saturday, my sister comes and takes me to see my mother and on a Sunday, my sister comes.

I havn't been on holiday or away for a weekend in the last two years. It's partly because I can't afford it and partly because I'm obsessed with my home.

I watch a lot of TV. It's company when I am on my own. I read the paper but I can't concentrate on reading. I havn't read a book for years. I can't do any physical activity because of my bad leg.

I specially like writing on my own, or in the group. I can get my feelings down which makes me feel better. I havn't been to any meetings of the Islington Mental Health Forum. They have sent me material about the meetings but it is too far for me to go with my bad leg and especially in the winter in the dark. I had my bag stolen once. I might consider going if it was at a different time and closer to where I live.

#### Community Life

The area I live in is rough but it is a nice street. The neighbours are not really friendly. They are very quiet and only say hello. I don't really drink but I've been to the local pub, the Elizabeth Arms. I use local shops, I go to Liptons mostly. I don't go to church or use the library. I did go to the cinema last Saturday but that was the first time for a long time.

#### Finances

I used to be on Invalidity Benefit but since I was 60 I've got the Pension. I havn't really had any problems with the DSS but I went to the People's Rights about my Income Support because I had paid too much Rent and Poll Tax, fifteen pounds a week, and they refused to give it back. They said they would put it on next year's Poll Tax. I just wanted to have the money. I wanted to have my hair done and

to give my daughter some money because of all the help she gives me and I could have had a new carpet. I was supposed to be getting the money but I am still waiting. Every day I look for it and that adds to my problems.

#### Social Network

I see my daughters regularly. They come to see me, and my sister brings my mother to see me.

#### Professional Contacts

I don't have a social worker. I see my GP for medication. I don't see a CPN and I don't go to the Whittington any more. I used to see Dr Robertson at the Whittington. If I have a problem, I go to my GP. I used to discuss my problems at the Group at Pine Street. I was sent to Counselling by the Family Welfare but I wasn't happy with the counsellor. She was nice but I didn't feel comfortable with her so I didn't continue. I wanted to carry on with counselling but not with that counsellor. She wanted me to go back in time with my family situation, to my mother and sister, to sort my problems out.

#### Additional Topics

I feel that nobody understands my problem of obsessive behaviour in that I imagine other people, for example, my sister doing the obsessive acts. Somebody said I should read about it and try to help myself. I think this would be a good idea. I would like some practical help on how to stop my obsessional behaviour, some leaflets I could read.

### Researcher's Comments

Doreen was well-dressed and looked younger than 60. She was very nervous at the beginning of the interview, but seemed to relax after the researcher gave her a sweet for her dry mouth. She seemed so distressed when talking about her obsessional problems at the end of the interview, that the researcher agreed to try to find some material for her to read and to give it to her through the Centre's Duty Service. She seemed relieved and very grateful. She said it had been good to talk about her problems and other things, and was surprised to receive the five pounds for participating immediately after the interview. When the researcher saw her later in the day in the Centre Cafe she was very friendly and looked much happier.

The researcher supplied Doreen with some material on obsessive behaviour via the Duty Service, a week later. The Centre Manager said they had suspected she was experiencing problems and this had given them an opportunity to help her.

### Conclusions

Doreen appeared to have had a series of very stressful life events which eventually led to her breakdown: husband's drinking; one son being taken away and another dying due to a genetic disorder; sterilisation, and while she was recovering her husband began to have a relationship with his dead brother's wife.

Doreen had been in Friern for long and shorter stays, the Royal Free for a short stay, and had also attended the Whittington Day Hospital. However, she continued to have

serious problems with obsessive behaviour, which were controlled by medication. This may have been because her ex-husband and sister-in-law lived near her, and she had not been to see her son who had been taken away at birth. Doreen's most recent therapist had suggested that the root of her problems may be found in her family history, on the female side. There certainly seemed to be a strong tie between the female members of the family, and it was possible that because they made up Doreen's social network, she was frightened of confronting anything negative in her family history which would destroy this. Hence, her desire for counselling, but not by the counsellor who was beginning to reveal the reason why she was unable to cope with her problems.

Doreen had not been in Friern since 1982, so she was not part of the closure programme. However, in view of her previous multiple admissions, unresolved problems, and positive feeling towards the interview situation, the researcher concluded that Doreen could benefit from some of the professional support offered to people in the closure programme, for example, from a social worker or member of the CMHRT. Hopefully, the Centre's Duty Service would be able to help with this.

The researcher concluded that Doreen did not want to be associated with people with mental health problems since she had preferred the Centre when it had organised activities because it was more like a College, and she did not seem to be keen to go to the IMHF although it was only a short bus journey away. The researcher would, therefore, recommend

that Doreen be linked to a Befriender since, if she became alienated from her social network of female family members due to therapy, she would become socially isolated. Again, it was hoped that the Centre's Duty Service would be able to organise this.

Doreen considered the Halliwick Wing of Friern to have been a positive experience, but she had negative memories of the main part of the hospital. She was convinced that she had witnessed bad incidents with staff, even though she was accused of fantasizing. Since there appeared to be very real causes of Doreen's breakdown, and because she came across as being a very forthright person in the interview, the researcher concluded that she had not imagined these incidents.

Doreen's negative memories of Friern Hospital did not mean, however, that she was in favour of the hospital closure. From her own experience, she concluded that people may need to be in hospital when they became ill, otherwise the burden could fall on their family to look after them. The researcher concluded that it was Doreen's positive experience of the Halliwick Wing that led her to suggest smaller hospitals for people who became ill.

## C O L I N

### Background

Colin is 41 years old and single. He had had short stays in Friern while the closure programme was in progress.

### Life in Hospital

I had a series of short admissions at Friern. I liked the building because it was low, but not the length of it. I used to suffer from anxiety and panic attacks. The staff thought it was drink but then one charge nurse realised that I was really suffering from anxiety. Some staff were all right but some were off-hand and could be nasty. I was given drugs for vitamin C deficiency because of the drinking. The last time was in January 1990. I had three binges of alcohol.

I thought that Friern was not as bad as it seemed. Windows were smashed and that but it was all right. I didn't know Friern was going to close. I feel sad about it closing. I like the hospital in a way even though there were rough types.

### Domestic Life

I live off Essex Road at the moment. It is a council estate, it is noisy and the kids are a nuisance. I've lived there since January 1990. I'm not too happy because it is rough. I live on my own. I do my own cooking, cleaning, and shopping. I do my laundry at the Centre, and gardening.

### Daily Life

I've been coming to the Centre, the drop-in since January 1991. Since the beginning of the year, I've been coming every day, Monday to Friday but it is closed on Thursday. I attend the Men's Group where they discuss problems. In my case, it's drink. The art classes haven't been functioning properly since January/February. I think the Centre is all

right. The thing I don't like about it is that it has taken a long time to get the activities together to make it the Resource Centre. It is difficult to make a social life because everyone has their own problems.

The thing I'd like that is not available is a Befriender. Choice in Holloway Road are supposed to be organising it. I suffer from anxiety and panic attacks, in the streets, in the parks. I have medication for it. Choice say they have to get somebody who is an ideal match. I've been waiting for a year.

I'd like to come to the Centre at the weekends but it is only open alternate Sundays. I don't go to any other Centres at the moment and I don't do any work I get paid for. I couldn't possibly work at the moment. I can feel my face getting very hot.

I usually come to the Centre until about 7.00 pm, then I go home. I can't go out because of the people. I went to Hastings on a day trip with the Centre which was all right. I thought I would be too anxious but I managed. I went to see my father and sister in Devon last Christmas.

I watch a lot of TV. I don't read because its boring. I don't do any sports. I specially like gardening at the Centre, I am a bit of a workaholic.

I havn't heard of the Islington Mental Health Forum.

### Finances

I have just about enough money to live on if I budget. I havn't had any problems with the DSS but I've had a few problems with Housing Benefit. I spend most of my money on



cigarettes. If I am very hard up I have to buy roll-ups and I have to get second-hand clothes.

### Community Life

The area I live in is noisy. I don't see very much of the neighbours. I have one good neighbour. I don't go to the local pub because I had to give up drink through my illness. I go to the supermarket sometimes if I am able but I prefer smaller shops. I don't go to church but I am very religious. I pray every day to be rid of my illness.

### Social Network

My father and sister write to me once a month and I write to them. I don't see them as it is too far.

I don't have any friends, only my friends at the Centre. It is difficult to know people outside.

### Professional Contacts

I have a social worker, and I go to my GP for medication. I haven't been to the Whittington. I've been turned down there. The policies are too hard. They will not admit you if you have been drinking for 24 hours. Friern will take you in and give you medication. If I have a problem, I contact my GP. He can write a letter of referral.

### Researcher's Comments

Colin was smart and well-spoken, but had a rather superior attitude. The researcher first met him with a Centre Worker just before the interview, which was scheduled for 2.00 pm. He was very friendly but said he thought that the interview was going to be at 1.00 pm, that the interview had been

cancelled, and that he was about to go to the Men's Group. He offered to miss the Men's Group but the researcher arranged to come back when it was finished, when Colin would come to a room on the first floor for the interview.

When Colin arrived for the interview, he said he did not like heights and seemed very anxious. Neither the Centre Worker nor Colin had mentioned this when the researcher had asked him to come to the room on the first floor. There was no other room available to conduct the interview, so the researcher shifted the furniture away from the window and nearer the middle of the room, but Colin still seemed very anxious. Half way through the interview, he was obviously feeling very distressed. She asked if he wanted to stop the interview but he said he wanted to go on. He said the problem was that he was still too near the window and he was very high up. She moved the furniture again so that he was next to the door and turned his chair round so that he could not see the window. He seemed better and the interview was completed. He was very pleased to receive the five pounds for participating.

After the interview, Colin became very distressed at the top of the stairs. The researcher helped him down slowly, and he calmed down on reaching the ground floor. When she saw him later that afternoon, he seemed in good spirits and was boasting to his friends about his interview.

### Conclusions

Colin was keen to talk about his problems and to be associated with other people with mental health problems, in

fact, his only social contacts seemed to be at the Centre. The researcher concluded that Colin could benefit from some constructive work to do, some relaxation classes, and somewhere to go at the weekend when the Centre was closed to stop him brooding about, and increasing, his anxieties. He could also benefit from having a Befriender to go out with, to help him overcome his anxiety, and she concluded that it may be his rather superior attitude that was making it difficult for Choice to find someone for him.

Colin had had a series of short stays in Friern while the closure programme had been in progress, and the researcher concluded that he may need further periods in hospital in future. Colin felt sad about Friern closing probably because he had had problems in the past being admitted to the Whittington. She, therefore, concluded that the re-hospitalisation of Colin may be difficult when Friern finally closed and the District General Hospital was the only option.

## C L I V E

### Background

Clive is 57 years old and single. He had been a long-stay patient just before the Friern closure programme began.

### Life in Hospital

The last time I was in Friern, I only went for a haircut. It was the week that Elvis Presley died. It was pretty good

I suppose. Then I moved to the Whittington. I liked the Whittington better.

While I was in Friern I went to the North and South Workshops. Two people at the hostel go to the South Workshop now. They were asking me about you because some people are coming to the hospital to make a documentary.

I knew that Friern was going to close next year. The hospital closing won't make any difference to me but where will they all go?

### Domestic Life

I live with Mrs Corcoran who is Irish in a hostel in Palmerston Road, Palmers Green. I've lived there for six years. I share a room. It's all right there, there is a cooker. They do cooking, cleaning, laundry, and shopping for you. There is a garden but I don't do it.

### Daily Life

I came to The Avenue from Finsbury Town Hall. I come every day except Thursday when it is closed, and Sunday. I work behind the Canteen on Wednesday. I get five pounds for it. I like the Centre. I can't say there is anything I dislike about it. There are new things now. There's nothing I'd like to do that isn't available. I am best off where I am. There are not any times I'd like to come when it is not open but that's because I live in Palmers Green, in a hostel in Palmerston Road with Mrs Corcoran. It would be too far to come. I have to leave every afternoon to get back for tea.

I don't attend any other Centres. I did go to Hanley Road when they were doing the Avenue up. I liked it about

the same. I'm going to try and do work on Reception because there are more people waiting to work in the Canteen.

On a normal day, I come to the Centre, then go back to the hostel. I mostly watch TV in the evening, sometimes I go out for a cup of tea. I do the same at the weekend and on a Saturday morning I might go out for a cup of tea.

A month ago I went to Windsor Safari Park for a day, and on 6th July I'm going to Hampton Court. That is with the hostel. I watch a lot of TV because other people in the hostel do. Some people have a TV in their room but I havn't. I read newspapers but not books. I like to watch football. There's nothing I specially like doing on my own or with other people.

I have heard of the Islington Mental Health Forum, I think there was a poster up.

### Finances

The money for my accommodation and food is deducted, then I get twelve pounds one week and twelve pounds 50 pence the alternative week. I havn't had any problems with the DSS while I've been living there but I did once with Archway Towers. They took a long time to pay. My Giro didn't come for a long time. I was owed one hundred pounds but she gave me ten pounds a week and when I moved out she said you've had it so I'm going to keep it, so I never saw it.

I spend most of my money on cigarettes. It is a struggle to live on the money I have but I pay for my lunches at the Centre.

### Community Life

There's no trouble at the hostel but it is a rough area.

There have been two murders at the Salisbury pub and there are other incidents of violence.

I don't really know the neighbours. I don't go to the pub because I can't afford it although four of us from the hostel went to the Western pub for a birthday. I used to go to the park. I don't go to church but I go to jumble sales at the church. I go to a cafe on the corner at weekends and I go to the bakers. I have only been to the cinema once in five years to see My Girl which is really a women's film.

### Social Network

I have a brother who works in the Post Office. He retires next year. He used to come to see me every three weeks but I havn't seen him since Christmas. I used to see him often.

My friends are at the Centre and the hostel, we have been for a drink.

### Professional Contacts

I have a social worker, Ann Malcolm, in Edmonton. My GP, Dr Jenkins, is at Gillan House in Palmers Green. I used to have a CPN for my injection but now I go to Highbury Grange. I saw my social worker in March at the Whittington. I used to have my injection there. I have seen Dr Baxter once. If I have a problem, I go to my GP or a doctor at the Whittington or that's what they say.

### Researcher's Comments

Clive was well a turned-out, quiet, gentle person. He seemed nervous at the beginning of the interview but was very relaxed and chatty by the end, and did not seem to want to leave. He was very grateful to receive the five pounds for participating.

### Conclusions

Clive was in a similar situation to Carl: he would have been classified as long-stay if he had not been discharged before the Friern closure programme began; and, he did not seem to regard his Hostel in Palmers Green as a 'home' although he did have friends there. The researcher, therefore, concluded that Clive, like Carl would have benefited from being part of the closure programme because he would have been discharged to a more homely environment in Islington within a short travelling distance of The Avenue.

Clive, however, appeared to have had almost the same level of professional support as the ex-long-stay patients, although this seemed to be split between two boroughs, Islington and Haringey, and did not include the support of residential project workers. He had been told who to contact if he had problems, although he had not used this resource when matters were causing him concern, as seen in his resignation to the fact that he had not had a visit from his brother for six months, when he was accustomed to seeing him regularly.

Clive had experienced financial problems in the community - he had not had the money he was entitled to, and

he had not had enough to spend on leisure activities. However, he had more recently been able to earn some extra money at the Centre and this may become a permanent feature since he seemed willing to 'move on' from working in the Canteen to the Reception.

The researcher concluded that Clive's social network seemed to be confined to people with mental health problems, and that it was unlikely that he would be able to move on to more independent living because of his age and because he was accustomed to having everything done for him at the Hostel. She, therefore, further concluded that Clive would have made more progress in the community if he had been part of the Friern closure programme because, with the support of residential project workers, he may have been able to become more independent and broaden his social network.

Although Clive, like Carl, did not expect to need hospital care again, he too was concerned about Friern closing because of what would happen to the patients there.

## C L A R E N C E

### Background

Clarence was 52 years old and single. He had been short-stay before the Friern closure programme began.

### Life in Hospital

I was in Friern Barnet and Mapperley which is 17 miles outside London. That is where I met Lizzie Franks. That



was the only girlfriend I ever had. I don't see her any more. She used to come to see me but it is too far away.

It was a long time ago when I was in Friern. About four or five years ago for about four or five weeks. I was in a mixed ward, males and females and nurses. The nurses were nice in Friern Barnet. They really looked after you - Paula, Joyce, Nina.

I was living in Essex Road when I went into Friern. The kids there threw bricks at my window. But Friern was all right, the doctors and nurses. I had tablets and food. I didn't do anything like the Workshops. I would just sit in the fields and Joyce who went to Hastings would come and sit with me and I would explain my troubles. They do so much for you in Friern, they do everything for you to get you well. When I was in Friern, Gemma Smith was my social worker and she said she would move me somewhere else.

I heard that Friern is going to close. I think it is terrible. Where are they going to move them nurses to, up the Whittington?

### Domestic Life

I live in Grenville Road, Stroud Green, Finsbury Park. I live in a house with Susan. There is just me and Grace Roberts. It is an ordinary house, not a hostel. I have been living there for six years. I am happy there. Susan does everything for me. I get breakfast, tea, and dinner. She does all the cooking. Me and Grace do some washing-up and clear up the cups and give them to Susan. I have a bath on Friday and Susan does my washing. Susan does the

shopping but I buy Go Cat for Ginger the cat, it can last him for two weeks. We are not allowed out in the garden, I don't know why. It is only Susan and her family who are allowed out there. She has strict organisation and routine.

I forgot to tell you that I went to Tollington Park before Susan's. I had a fight, well not really a fight, with a bloke there.

### Daily Life

I have been coming to the Centre for 5 or 6 years, I can't remember exactly. I come on Monday, Wednesday, and Friday. On Tuesday and Thursday I go to Hanley Road because this Centre is closed on Thursday. I come after breakfast, whatever time I have that. I usually get here about 9.30 am. I usually stay til 3.00 pm. I have lunch and a cup of tea in the afternoon. Sometimes we book out at 1.00 and then come back for tea. I never stay late.

I like this Centre because you can please yourself what you do. You don't have to go to the Men's Group now. I used to go sometimes. Sometimes we play Musical Chairs. There's nothing I don't like about it. It is all right. I like coming here because it gets me out of the house. I prefer it now but I would like to do Art and they don't do it now. I can't draw but I like to paint, watercolours. I like colours. Red, green, and blue.

I have Tuesday off and go to Hanley Road. I don't come on Sundays, I go to Hanley Road about 12.00. I have lunch there as they do cheap rolls. I go to Hanley for a bit of a change. It is a bit smarter there, there is a living room

with better chairs for sitting and the girls are nice. They always speak to me.

I sometimes used to go to the MIND Centre, the Links Club in Tufnell Park but I havn't been there for ages. I didn't like it very much because it was untidy. There were terrible sofas and some of the blokes, not all, but some were dirty. They never had a wash.

I don't do any work. I don't work on Reception or the Canteen. I am content just to come to chat to people. I usually just sit about, then have lunch and then in good weather, we go to Highbury Fields. We usually come back for a cup of tea because it is only ten pence. Then I go home and watch tele and have my dinner. I watch Neighbours and Home & Away. If it is nice, I go for a walk in Finsbury Park.

At the weekend, I watch tele and go sunbathing in Finsbury Park, and go to Hanley Road on Sundays. I havn't been on holiday or away for the weekend in the last two years. The last time I was on holiday was with Mary Clark to North Wales, that was when she was at Highbury. I havn't been on holiday for years to Clacton-on-Sea or anything. I havn't been on any day trips because they go on Tuesdays and I don't come on Tuesdays. I'm not really bothered about not going on holiday. I don't like to go away too far and I get travel sick. I used to take Quails for it.

I don't read but I like watercolour and colouring books but there are only children's colouring books. Donald Duck and Mickey Mouse, not Robin Hood and his Merry Men. I am fascinated by colour, red and green. I watch football on

television, the league matches, and Saint & Greavsie which is on for 35 minutes but is continuous. I specially like coming for a chat, being sociable.

I have been asked to go to the Islington Mental Health Forum a long time ago. I wouldn't want to do it because I wouldn't know how to do it. It might go too fast and I would panic. I wouldn't want to go even if some other people from the Centre were going.

### Finances

I think Susan pays the rent. I don't know, I'd have to ask her. I haven't had any problems with my money. Susan gives me thirteen pounds 25 pence on a Monday, early. On Monday, she got up early, about 7.00, because she had had a Barbecue with her sister Clara and she gave me the money and I was here at 9.30.

I spend most of my money on cigarettes. I buy 20 XL. I would be able to cope a bit better with ten pounds a week more. I have heard that some people get fifty pounds but that must be to pay for their food and rent.

### Community Life

I like the Finsbury Park area. I walk around Lancaster Road, and Tollington Park, and in Finsbury Park I sit in the American Garden.

I don't speak to the neighbours a lot. I will say good morning but they are very friendly people.

I don't go to any local pubs because I don't drink because it is one pound 30 pence a pint. It is too expensive. I haven't had a pint for years. I don't use the

local shops because Susan does the shopping on Monday. I buy Go Cat for the cat and it likes Felix.

I use Finsbury Park and Highbury Fields. I don't go to the library or church. I don't use cafes because I can come into the Centres and get tea for ten pence. Outside it is 35 pence a cup. I haven't been to the cinema for years. The last film I saw was the Ten Commandments. It costs about four pounds. If I had more money I would go to the cinema.

#### Social Network

I don't have any contact with my family because they don't know where I live. My social worker in Essex Road, Douglas, was asking me about them. I have a brother and two sisters, one in West Virginia. Douglas was talking to me about contacting them. Michael is from London.

Friends? I usually go about on my own. I meet a fellow called Andy Newton over in Finsbury Park. He is quiet, he doesn't come out much and then after an hour he goes back indoors. He stays inside too much because of his illness and that makes him worse. You have to get out, like me, I am out all the time.

#### Professional Contacts

I saw my social worker, Douglas, every month at the Whittington. I am getting a coloured woman in his place. She is going to come and see me. I don't have a GP and I don't see a CPN. I have never been to the Whittington. I was once in UCH when I was on the railway and had acid burns.

If I have a problem, I tell Susan. She can usually sort it out. I don't like to talk to her about more money because I don't think she can do anything about that.

#### Researcher's Comments

Clarence looked pale and thin. He was slightly nervous at the beginning of the interview, but soon relaxed and became very sociable, although he seemed to have difficulty in remembering things. He did not seem to want to leave when the interview was finished, and was very pleased to receive the five pounds for participating.

#### Conclusions

From the way Clarence spoke, sat, and behaved, the researcher concluded that he had once been institutionalised for a long time - he may have been in Mapperley Hospital or had previous longer stays in Friern than the 4/5 week stay he admitted to.

The researcher concluded that Clarence seemed to be too complacent. For example, he just seemed to accept: having no contact with his family even though he would like to see them; that the Art Classes had stopped at the Centre although he enjoyed painting; having insufficient money but not asking his Carer if he could have more; and, not asking his Carer why he was not allowed in the garden when he obviously enjoyed being outside, judging by his use of various parks.

She, therefore, concluded that Clarence could benefit from professional input from the CMHRT to enable him to, for example, vocalise his desire to paint; take-up work in the

Centre Canteen, since lack of money was an impediment to him in engaging in leisure pursuits; and, quash his fears of what would be expected of him at the IMHF, so that he could attend their meetings, thereby broadening his social network and spending less time on his own.

Clarence had very positive memories of the staff in Friern Hospital, probably because he felt that they had looked after him well when he was very ill. This would explain why he was more concerned about what would happen to the staff than the patients, when Friern finally closed.

## C H A R L E S

### Background

Charles was 65 years old and single. He had been a long-stay patient before the Friern closure programme began.

### Life in Hospital

I was in Friern 10 years ago. I was in for 2 years, 1979-81. I was on an all male ward. I liked Friern. I tried it and I stayed there. I had nothing against Friern, it was a nice place. I got on with the nurses and made friends up there. I went back to see them once, not recently, but I haven't been up there since. I used to go to Occupational Therapy. I liked that. That is why they first sent me to The Avenue from there.

I've heard that Friern is going to close. I am all right, I have no worries. I used to worry that I would finish off on the streets, now I am in the Home I feel safe.

I feel safe in the Home. I would be worried about the hospital closing if I was not in the Home. Sometimes when you get out of hospital, you don't know where to turn. I think its hard people being turned out of hospital now. I feel stronger, more able to cope with things than I used to be.

#### Domestic Life

I live in a Private Home for the Elderly in Essex Road, only a bus ride away. I've been there for 10 years. I share a room with another man. I like living there. Everything is done for me, the cooking, cleaning, laundry. They run your life completely.

#### Daily Life

I have been coming to this Centre for 10 years, since coming out of Friern. I come three times a week, Monday, Wednesday, and Friday. On Tuesday I go to the Library and on Thursday it is closed. I only read the paper and drink tea here, and I talk to Clarence White. I like the Centre because it is free and easy-going. They don't expect you to do anything really. There's nothing I dislike about it. You can do anything you like here. Sometimes I come on Sunday. I don't go to any other Centres.

I usually come to the Centre about 9.30 am and stay most of the day although sometimes I go home to have dinner. In the evening, I watch TV. At the weekend in the summer, I go out in the garden. I watch TV at the weekend too.

I havn't been away on holiday or anywhere for a weekend. I don't wish to go. I read newspapers and



magazines but not books much. I am too old for sport but I watch football on TV. There's nothing I specially like to do.

I havn't heard of the Islington Mental Health Forum.

### Finances

I don't have any problem paying for my accommodation and food. I get seven pounds a week pocket money. I spend most of it on cigarettes. I smoke 10 a day so that's where all the money goes.

### Community Life

I like this area. I like most of the neighbours but then I get on with most people. I don't go to local pubs or shops. I don't go to church or the cinema. I go to Highbury Fields and the Library on Tuesday.

### Social Network

I have two brothers, they are both retired now. They moved to King's Lynn two years ago. They come to see me sometimes but I havn't been to visit them in King's Lynn yet.

Clarence White is a friend whom I see regularly.

### Professional Contacts

My GP is Dr Lovell in the Home. I don't have a social worker. I don't go to the Whittington for any reason. I take tablets but I don't go to hospital. If I have a problem I tell Mr Black or the Matron at the Home and they are understanding.

### Researcher's Comments

Charles was sun-tanned, well-dressed and looked younger than 65. He seemed to have a hearing problem which meant the researcher had to repeat some questions. This also made it difficult for her to probe into the meaning behind some of his replies. Charles looked a bit dazed at the beginning of the interview, and the researcher felt that he had only agreed to take part in the research for the money. He did, however, answer some questions at length, and some of his replies were very graphic. He was delighted to receive the five pounds for participating.

### Conclusions

The researcher concluded that Charles felt that the Home in which he lived was a 'home', a place where he felt safe, and where there were people who understood his problems. He did, however, seem slightly resentful that these people ran his life completely.

Charles did not have to do anything for himself in the Home and he thought the Centre was easy going. The researcher concluded that perhaps too little was expected of Charles, in view of his perceived physical agility. He may, therefore, benefit from input from the CMHRT to focus both his physical and mental energies.

Charles said that he could get on with most people but he did not seem to have a very strong social network. He named Clarence White as his friend but this friendship was not reciprocated in Clarence's account, unless Charles was

included in the 'we' that Clarence mentioned when talking about The Avenue. Charles seemed to be disappointed that he had not been to visit his brothers in Kings Lynn and also that he had no money left, after paying for his accommodation, food, and cigarettes, to spend on leisure activities. The researcher, therefore, concluded that Charles could benefit from having a Befriender.

Charles had positive memories of Friern Hospital and clearly vocalised his fears about leaving hospital and ending up on the streets. Although he, personally, was not worried about this now that he was living in the Home, he was concerned that this might be the fate of others, when Friern closed.

## D O R O T H Y

### Background

Dorothy was 53 years old, divorced with one daughter. She had been a short-stay patient while the Friern closure programme was in progress.

### Life in Hospital

I was in Friern three or four years ago. I was in a locked ward because I wanted to get out and go home. I used to like the grounds, it was like a stately home, lots of space. If I had not been in a locked ward I would have used the grounds. It was very pleasant there. I had no problems. There were long corridors, though, and it reminded you of old dormitories.

Then I moved to the Whittington. I was there for longer, nine months. There was no space or grounds at the Whittington so I like Friern the better of the two. I didn't have any problems at the Whittington. I went to occupational therapy from time to time. I can use computers so they were trying to help me to get back to work but I couldn't concentrate. I'd be interested in a work scheme for that. I was in the Whittington again last year, October.

I knew Friern was going to close because the nurses told me. I wonder how people will cope. There's a move to the community but it will not be able to handle everybody.

#### Domestic Life

I live in Petherton Road in a Housing Association property. I have lived there for 15 years. I usually live on my own but I have a friend living with me at the moment. I like living there. I do my own cooking, cleaning, well, everything for myself.

#### Daily Life

I've been coming to the Centre since January 1992. I come quite often, most days, usually four days a week. I don't take part in the activities although I have been to the Women's Group. I like to just sit around and play chess, and mastermind. I usually play chess with Carl. I met him in the Whittington. That is where I learnt how to play chess. I used to think it was too complicated to learn but now I really enjoy it.

I like this Centre because it is informal, somewhere to come and have a chat. There's nothing I don't like about it. I am quite happy with the way it is and the times it is open. Sometimes there's the opportunity to stay late. I think these Centres are a marvellous idea. I don't usually attend any other Centres because I live near this Centre in Corsica Street.

Years ago I went to Finsbury Town Hall which was The Avenue before. I was not keen on that because it was not a drop-in. I have been to the Links Club. I get five pounds for working on the Reception here but it is better to work in the Cafeteria.

On a normal day, I do some jobs at home and then get ready to come to the Centre. I usually come from 11.30 onwards. Some days I have lunch, quite often I stay for the afternoon and occasionally I stay til 8.00 pm. Sometimes I will go home and pop back in the evening. I live near. I have people I know round for a meal occasionally.

I do similar things at the weekend. I see my sister, friends, and relatives. Visiting is my pastime. I haven't been away on holiday or for the weekend in the last two years. I was ill last year, that's why.

I like television and watch it fairly often. I used to read but I can't concentrate now. I have lots of books but I only read occasionally. I used to play badminton but not now. I play table tennis at the Centre. I specially like playing tennis. I learnt it in the hospital 10 years ago and then took it up again. It is easy to learn.

I havn't heard of the Islington Mental Health Forum. From what you've said about it, I would possibly be interested in going along.

### Finances

My finances are a bit better at the moment because I have a friend staying in my daughter's old room. Before that it was impossible to pay for anything. I havn't had any problems with the DSS but it is just not enough money even with Housing Benefit. There is no money left to spend. When I became ill I lost track of money and got into debt. When I was in hospital I had a lot of debts. If I had fifteen pounds a week more, it would be better, then maybe I could afford a night out.

### Community Life

There are all sorts in the area I live in. It is quite pleasant. I go to the local pub and shops, and to Clissold Park. I don't go to church or the cinema.

### Social Network

My daughter lives near, round the corner, and I have a sister in Finchley. I go to see them mostly.

If I have a problem, I contact my family. My sister is very good with financial problems. When I was ill my sister and daughter were both very good.

I have friends at the Centre, friends in the area and all over, but mostly I see friends at the Centre.

### Professional Contacts

I don't have a social worker. I don't see my GP a lot, only for certificates for three months because I'm not able to work. I don't go to the Whittington at the moment. That was where I met Carl 10 years ago. He was a long-stay patient.

### Researcher's Comments

Dorothy was a very young looking 53, well-dressed, but rather overweight. She was very friendly, articulate and easy to get on with. She was not at all nervous and seemed to be looking forward to having a chat. At the end of the interview, she said that she had really enjoyed it, and was very pleased to receive the five pounds for participating.

### Conclusions

Since Dorothy did not mention her husband at all during the interview, or talk about her illness in any detail, the researcher concluded that her divorce and illness were inter-related. Divorce may have initially caused her financial problems, and financial problems certainly seemed to be in some sort of relationship with her illness - either causing or being caused by it, or both.

The researcher concluded that Dorothy was a very capable person and since she had computer skills, employment seemed a real possibility. However, she did not like structure, which is why she preferred the Centre since it had been a drop-in. In view of this, and the relationship between her illness and financial problems, she concluded that Dorothy could benefit from becoming part of a sheltered

Work Scheme to augment her benefits and prepare her for the employment market.

Dorothy seemed to be a very sociable person and, as she had expressed interest in the IMHF, and because of her reluctance to talk in detail about her problems, the researcher concluded that she would enjoy and benefit from attending the Forum's meetings, where people are very open when talking about their experiences.

Dorothy appeared to have a strong social network of family and friends, and this often seemed to compensate for her lack of professional support. She had had several short, but recent, admissions to Friern and the Whittington and if her particular problems continued to be unresolved, the researcher concluded that Dorothy would require hospital care in the future.

Dorothy appeared to have had a positive experience of hospital life. She preferred Friern to the Whittington because of the spacious grounds, and the researcher, therefore, concluded that when Dorothy said she wondered how people would cope when Friern closed, she was including herself in this.

## C H R I S

### Background

Chris was 47 years old and single. He had been a short-stay patient in Friern long before the closure programme began.



### Life in Hospital

I was in Friern 16 years ago, as a voluntary patient and sectioned. I was in Prestwick, I was a misplaced person. I ended up in Friern because of gambling, drinking and tablets. I havn't been in Friern since 1973. I was in for five weeks in an open ward, mixed but dormitories, where I could come and go. It was quite nice. Then I was in for a short stay of two weeks. The people were very nice, I had no hassle, no problems. I was in a locked ward for 5 days. I asked the police to put me in the locked ward because I was depressed and down. You could ask the police to do that. They took me to Friern in a van.

I'd heard that Friern was going to close. I think the streets will be littered with sick people. I think the State will put people who would have gone to Friern to special hospitals like Broadmore and Rampton, but special hospital is a cliché, they are really like prisons. Prison is where I had bad experiences. I was there in 1977 for 12 months but I got out in 8 months. I felt like I was in obscurity. I admire people like Jimmy Boyle who have completely turned their lives around. With regard to closing Friern, there are people who will be better out than in, but they are doing it to save money, of course they are. It is primitive. There are people who are too ill to be discharged and who won't take their medicine.

### Domestic Life

I live in a Council flat just two minutes walk from the Centre. I have been living there for 16 years. I live on

my own, but at the moment I have a pal staying for a month or two until he gets his marriage sorted out. I think it is better having someone else living there. I do everything for myself, cooking, cleaning, everything. I don't have a garden. I usually eat at home although I will have a coffee and sometimes a sandwich at the Centre.

### Daily Life

I've been coming to the Centre since January 1992 when it became a Resource Centre. I didn't come to it when it was The Avenue because it was too restricted. Now it is a drop-in, I come two or three times a week.

I've been to Discussion Groups on the running of the Centre on Wednesdays. Usually I just come in and out. I work on the Reception on Tuesdays for three hours for which I get five pounds. I like the Centre as a drop-in because I like to keep on the move. It is OK for me as it is, I wouldn't like to come if I was forced to come. Some people are on an order to come.

I would like a Swimming Group, and I would like it to be open on Thursday and Saturday, and I would like to go on Day Trips.

I've been to the Links Club run by Islington MIND. It has its ups and downs, some people can be disruptive.

I am a volunteer for a Play Group for which I get a few pounds. I don't declare it because it is just a token. I've been doing that for 7 years. It's like a Youth Club. I like the kids. I am old enough to be their grandfather. I've been on trips with them in the summer. I got a chance

of another afternoon at Eden Grove but that was with kids with learning difficulties. With the Play Group, it was not official, no application form, no interview. At this second venue, I had to fill in an application form and they check with the police. I realise the sensitivity of working with children but I only had a conviction in 1968 for burglary. So I don't do that job.

On a normal day I am in and out. I also go to the Bookmakers. There is racing from Scotland today. For the last three months, I have been in a relationship so I usually watch TV with her in the evening. I have a friend whom I have known for 11 years and I spend time with him. We shared a gambling problem and were a comfort to each other. You can sort your problem by going to something like A.A. or you can share your problem with a friend and try to help each other.

On a Saturday, I like listening to the radio and I go to the Betting Shop. Sundays are boring, it is a really long day. I went to the cinema last week. I'd like more drop-ins on Saturday and Sunday.

I have been on Day Trips with the Youth Club. I don't stay over. I went to Alton Towers. I have been swimming at Eden Grove with handicapped children with special needs. There's not the money to go away for a weekend. I've been in London 20 years. I went to Manchester two years ago.

I like to watch television in the evening, in the winter. I like documentaries or programmes like World in Action. I like things about UFOs and mysteries. I don't like watching television in the summer. I read newspapers,

I left my Daily Mirror downstairs. I like books on topics, factual. There are plenty of books here. I like fiction in film. I went to see a film about J.F.K. Everyone who was alive can remember where they were on 22nd November 1963. There were so many coincidences between President Kennedy's death and the death of President Lincoln. I could name you a dozen.

I like swimming and I used to be into amateur boxing. I'd like to do that again but I would have to dye my grey hair.

I specially like good conversation, people with a sense of humour. You get a laugh at the Centre here.

I went to an open meeting of the Islington Mental Health Forum. There was a nice atmosphere.

I worked in the MIND office, short-listing people for interview for new vacancies. I got five pounds an hour for a week to 10 days.

### Finances

My finances have been OK recently. The doctor gives me certificates so I can get Invalidity Benefit. I have arthritis. If I was on Unemployment Benefit my money would be reduced drastically. I smoke 10 cigarettes a day and drink occasionally. I also gamble. I havn't lost any money recently. I have won more in the last few weeks than in a long time. Sixty-seven pounds and eighty-seven pounds on the dogs. Somebody said I should quit while I'm ahead.

### Community Life

The area I live in is quiet and peaceful. I'm in a Neighbourhood Watch Scheme. People are not very neighbourly. I come from an Irish background and have a lot of relations. People are more friendly in Manchester than London, and Ireland is very friendly. I think it is awful that people just walk by when somebody is lying on the ground. They see someone with one leg lying on the pavement, and they just walk past.

I went to the pub last week with my pal for a few drinks. That was the first time in two years and it was OK. I go to Sainsbury's for my shopping. I often take my woman's dogs for walks on Highbury Fields. They are a mother and daughter. I worry that I might catch some infection from the older dog.

I don't go to the Library but I should. I haven't clicked on yet. The Play Group I work in is connected with a Catholic School and Church but I don't go to church very often. The last film I saw was J.F.K.

### Social Network

My mother comes to see me from Blackpool. I saw my sister in Manchester two years ago. I have a living grandmother, which is unusual for someone of my age but I haven't seen her for three or four years. I write now and again to my family, and my mother has a key to my house for when she comes to visit.

I was engaged in the 60s. I could have been a grandfather now. I am in a relationship now and I've had previous relationships in the last three or four years.

There are a lot of friendly people at the Centre, but I consider friends to be people I have known for a long time, like my friend of 11 years.

#### Professional Contacts

I don't have a social worker as such. If I have a problem, I can contact one by appointment. I have a Probation Officer at Highbury Magistrates. I don't go to the Whittington Hospital any more although I had to go the other day because I had taken too many of my prescription.

#### Additional Topics

When I asked Chris if he wanted to talk about anything else, he said he wanted to talk about his Lifestyle and Relationships.

I feel that because my current woman friend can be depressed and unbalanced, this could affect me. It is a tame relationship because I need balance. She is a bit older than me and possessive. The longer you are around people, the more involved you get. It is difficult at the start, when you are just getting to know people, to tell them that you want to be independent, not to get involved, because you don't know if there is going to be a problem. I'm worried about being in a relationship with someone with mental health problems in case they bring me down and upset my balance.

### Researcher's Comments

Chris was very friendly, articulate, and well-dressed. He told the researcher he had bought everything he was wearing at the Centre's Jumble Sale for two pounds. He had not turned up the first time an interview had been arranged, and the person manning the Reception that day told the researcher that he had been ill. Chris did not mention the first appointment.

Chris seemed very elated after the interview, and wanted to continue chatting. He was very pleased to receive the five pounds because he could have a bet. It was very difficult for the researcher to break up the meeting. He said he would have been happy to talk to her without the money, and if she needed to talk to him again, without payment, he would be very pleased. He wanted to know how many other people were going to be interviewed and asked if she wanted to talk to his pal, even though he did not have mental health problems.

She told him that it was only people who had some connection with Friern Hospital that were being interviewed.

### Conclusions

Chris admitted to having had problems with drinking, gambling, crime, and emotional relationships, resulting in depression, but the researcher concluded that he had, or still, suffered from some of the symptoms of schizophrenia because of: his preoccupation with UFOs and conspiracies; the feeling of being in obscurity he had experienced in prison; his anxiety about being infected by a friend's dog;

and his concern that being in a relationship with someone with mental health problems would upset his balance.

Chris, however, seemed to be mentally and physically very able, although he did say that he suffered from arthritis. He clearly enjoyed his voluntary work and had derived a lot of satisfaction from the work he did for MIND. He seemed to regard his criminal record as a handicap to further employment but the researcher concluded that he wanted, and would greatly benefit from, more full-time employment - it would give him more self-confidence and reduce his financial worries. His money problems had been temporarily alleviated at the time of the interview because he was on Invalidity Benefit, had won some money, and had a friend staying with him. In view of his interest in swimming, and his former boxing career, the researcher concluded Chris would be an ideal person for the Centre to employ to organise sporting activities.

Chris had a good social network but his only professional contact seemed to be his Probation Officer. Although it was unlikely that Chris would need hospital care in the future, she concluded that he could benefit from having professional support from the CMHRT to help him with the concerns he had about relationships.

Chris had had a bad experience in Prison. In contrast, his memories of Friern Hospital seemed positive. He had asked the police to take him to Friern and regarded the time he had spent in a locked ward as being for his own good. The researcher concluded that Chris was a very caring, sensitive person with a strong social conscience. He was,



consequently, very concerned about the Friern closure because he felt that some very ill people would end up on the streets, especially since the hospital was being closed for the wrong reason - to save money.

## FINAL CONCLUSIONS AND RECOMMENDATIONS

### Biographical and Standard Information

A Table of biographical and standard information for the eight ex-patients interviewed is contained in *Appendix 11.1*. In summary, six single men and two divorced women with children, were interviewed. Their ages ranged from 41 to 65 and one person was classified as being a member of a minority ethnic group. Four people had had long stays and two had had short stays in Friern before the closure programme began. The remaining two had had short stays in Friern while the closure programme was in progress.

### Friern Hospital and Staff

The researcher concluded that the majority of those interviewed had positive memories of Friern Hospital. This seemed to be because it had been a place of safety when they were very ill, and when the alternative might have been 'the streets', prison, or becoming a burden on their families. Of the six people who mentioned staff, three seemed to have a negative image. This was in contrast to the Islington ex-long-stay patients who felt negatively about the hospital looking back, but positively about hospital staff.

She concluded that these differences may be

due to several factors. Firstly, people who had been long-stay pre-closure programme would have had sufficient time in the community to counteract the effects of institutionalisation and to view their time in hospital more objectively and, therefore, less negatively. Those who had been short-stay would not have been in hospital long enough to suffer the worst effects of hospitalisation and develop a negative impression.

Secondly, six of the eight ex-patients interviewed had had no connection with Friern for a very long time and did not expect to require re-hospitalisation in the future. Therefore, they did not fear the consequences of making negative comments about hospital staff. The two people who had had short stays in Friern while the closure programme was in progress and who would probably require hospitalisation in the future both said they would prefer to be admitted to Friern rather than the Whittington. It was, therefore, understandable that they did not make any negative comments about the hospital staff who may be responsible for their care in the future.

The researcher, therefore, concluded that the longer the time away from Friern the more positively people viewed the hospital but were inclined to speak negatively about the staff, but also the greater the possibility of re-hospitalisation, the more people spoke positively about both the hospital and staff. This conclusion was supported by the feelings expressed by the Islington ex-long-stay patients. Due to the progress they had made in the community, even those who had felt negatively about leaving

the hospital later expressed negative feelings about the hospital. However, since they had all, at least, witnessed people returning to hospital, and because they had not been living in the community for long enough to feel confident that they would not have to return to Friern before it closed, they expressed positive feelings about the hospital staff that they may have to rely upon, in the future, for their care.

### Hospital Closure

Although three people initially said that they did not know that Friern was going to close, everyone interviewed felt very negatively about the closure. Since the researcher had concluded that six of them were unlikely to need re-hospitalisation in the future, the negative feelings expressed did not seem to be motivated by self-interest but to be derived from their own experiences. They were concerned that people who were as ill as they had been: would have nowhere to go; would end up on the streets; be unable to cope; and, become a burden on their families. One person also thought that closing the hospital was wrong because it was being done to save money and another, who had some negative memories of Friern but positive memories of the Halliwick Wing, thought that there should be smaller hospitals for people to go when they were ill.

### Illness

The researcher concluded that the illness, whether this was depression, anxiety, or schizophrenia, of six of the people interviewed had arisen at a time when they were the victims

of social problems and/or had experienced stressful life events. Therefore, just as with the Islington ex-long-stay patients, there was much evidence in their accounts to support environmental theories of mental illness.

Five of the eight people interviewed had had some connection with the Whittington Psychiatric Wing, and two were likely to be admitted there in the future. The researcher concluded that this indicated heavy usage of this facility before Friern had closed. Since it was likely that some of the ex-long-stay patients may need periods of hospitalisation and because there would be other people with continuing and new mental health problems requiring hospital care in the future, she further concluded that it was unlikely that the Whittington would be able to cope with the demand for care when Friern eventually closed.

### Accommodation

Four people were living independently in Council or Housing Association properties in Islington, and four people were living in accommodation where everything was done for them - two in Islington, and two in Haringey.

The researcher concluded that the two men who had been long-stay but who had been discharged just prior to the implementation of the Friern closure programme, and who were living in a Hostel in Haringey, would have benefited from being part of this programme. This was because: they would have been discharged to a more homely environment in Islington; they would not have had to spend so much time travelling between their home and the Day Centre; they would

have had extensive professional support to enable them to become more independent; and, there would have been more continuity in their care. These would become increasingly important considerations as they became older and perhaps more physically frail.

### Community Attitudes

Only one of the people interviewed said he liked his neighbours. The others had either little or no contact with their neighbours, or did not consider them to be friendly. Even though the researcher did not conclude that any of these people would have been particularly visible or likely to draw attention to themselves in the community, they seemed to have experienced the same reaction from people in the community as the Islington ex-long-stay patients - they were ignored. The researcher, therefore, concluded that this may be a symptom of living in high-density, deprived communities. However, the majority of the people interviewed lived very near to the Day Centre they were attending, so they were within easy reach of an accepting and supportive mini-community.

### Financial Hardship

As with the Islington ex-long-stay patients, these people relied heavily on Benefits, had very little money left after paying for accommodation and food, and were continually 'scrimping' and struggling to make ends meet. Again, tobacco seemed to be the biggest consumer of their scant resources, and financial hardship had precluded them from joining-in activities in the wider community. Two people

were temporarily better-off financially because they were sharing their accommodation, two people had experienced problems in receiving the benefits they were entitled to, and two people had suffered stress because of financial difficulties, which had aggravated their illness.

Although these people generally seemed more skilled and self-confident than the Islington ex-long-stay patients, they also had few opportunities to earn extra money and, consequently, suffered the same financial hardship. The researcher, therefore, concluded that the same conclusions and recommendations would apply.

#### Work and Leisure Activities

Five of the people interviewed had no paid work. Three people worked in the Canteen or Reception at the Day Centre for a small payment, and one of these also did some local voluntary work. Everyone interviewed had some structure to their week in that they attended the Centre regularly, the majority on a daily basis. Some people liked the Centre because it was a 'drop-in' and little was expected of them, whilst others would have preferred more organised activities.

As with the Islington ex-long-stay patients, they spent a great deal of time on activities which cost little or nothing: watching television; reading; listening to the radio; playing games; and walking in the park. Similarly, visits to the pub and cinema were rare because of lack of money.

Three people spent some evenings and weekends with family or friends. However, the others only seemed to have friends at the Centre, and had little to do in the evenings and weekends. Hence, the requests from four people for Centres to be open at the weekends. In the last two years, one person had been away for a few days to visit family, and three people had been on Day Trips organised by the Centre. The others did not want, or could not afford, to go away on holiday.

The researcher noted that, since these people seemed to share the same plight with regard to Work and Leisure Activities as the Islington ex-long-stay patients, the same conclusions and recommendations would apply. In addition, however, she concluded that although the majority of the people interviewed seemed very able, little had been expected of them, either in their residential setting and/or at the Day Centre. They had talents and/or desires for work and leisure-related activities which had not been focussed or utilised.

To rectify this, she would recommend that the Day Centre where they were interviewed should retain its drop-in approach, but make organised activities available for those who wanted them, and that the users of the Centre should be involved in organising and running the activities they favoured. To encourage them in this, and to give them the opportunity to earn some extra money, they should receive a small payment for this involvement.

### Professional Support

Only one person had the same level of professional support as the Islington ex-long-stay patients. The others had much less. Three people had a GP and Social Worker, but four had only a GP, Social Worker, or Probation Officer. The four people living in supported accommodation, however, had some support from the managers of these establishments, and the two women living independently had a high level of family support.

The majority did not seem to know of any professional they should contact if they had problems, and those who did did not seem to think that they would actually ever contact them. They tended to rely on family and friends to help with problems, and those who only had friends at their Day Centre seemed to be resigned to the idea that these friends were too ill, or had too many problems themselves, to be able to help anyone else.

The fact that two people wanted to talk about their particular problems to the researcher at the end of the interview, and that another five seemed reluctant to end the one-to-one situation, led her to conclude that the Men's Group and Women's Group at the Centre, which were intended as a platform for people to talk about their problems, and the Duty Service which was set-up so that individual users of the Centre could ask for help and advice with their problems, were not fulfilling the needs of these people.

She would, therefore, recommend the provision of a service which used a one-to-one approach and invited individuals using the Centre to come along for a chat with



an 'outside' professional - someone whom they would be able to talk to in confidence, and who would be able to identify problems they may be experiencing, and channel them towards the appropriate people to solve these problems, for example, a member of the CMHRT.

The researcher concluded that everyone interviewed could benefit from some input from the CMHRT, although she doubted whether this Team would be able to cope with any additional clients. This showed the need to appoint additional professionals to support people suffering from mental illness in the community, who were not part of the closure programme, so that minor problems would not escalate to such an extent that hospital-based care became the only solution. She concluded that this need would become increasingly obvious as the Friern closure programme progressed and the Whittington Psychiatric Unit came under pressure to cope with the demand for beds that Friern had formerly met.

#### Social Network

The two women had regular contact with their families, and five of the men had occasional contact. Only four people said they had friends outside the Day Centre. The researcher therefore concluded that the majority, like the Islington ex-long-stay patients, had a small social network so the same recommendations would apply. In view of the low level of professional support they received, however, being part of a Befriending Scheme seemed to be very important. Also, because they seemed more socially skilled than the

Islington ex-long-stay patients, it seemed that it would be both easier and more appropriate to forge links for them with mainstream community activities, so that they could increase their social network with people other than those they had met through contact with the mental health services.

#### Islington Mental Health Forum

Only one of the people interviewed had heard of the IMHF. Of those who said they had not heard of the Forum, two said they might be interested, and two said that they would not be able to attend the meetings because they would not manage to contribute, or because their physical disability prohibited them from travelling to the meetings, although the researcher had concluded that this person did not seem to want to be associated with people with mental health problems.

She noted that since their general response was similar to that of the Islington ex-long-stay patients, the same conclusions and recommendations would apply. However, to generate more interest in the Forum's meetings, she would further recommend the introduction of a 'travelling' Forum which met on a rota basis at different Centres. This would mean that people attending Centres would be able to participate in the Forum, in a setting, and with people, that they were familiar with.

## CHAPTER 12

### MAIN CONCLUSIONS AND RECOMMENDATIONS

#### INTRODUCTION

The purpose of this chapter is to summarise the main conclusions and recommendations of this study.

This was a small-scale sociological study which attempted to evaluate the planning and implementation of the policy of closing Friern Hospital and providing care in the community of Islington (an inner London borough in the north of the capital with a population of approximately 160,000) via a variety of sources of secondary data, the views and experience of professionals involved and also the recipients of the policy - the clients and the community. It was a qualitative study of a small universe which was part of a larger universe being investigated by TAPS. By looking at this example of a major change in social policy from an in-depth qualitative perspective and including these two groups, the researcher hoped to redress the current imbalance in research of this nature, both in focus and approach.

#### THE RESEARCH QUESTIONS

This study was defined by the following research questions:

1. To find out if all the long-stay patients on the Islington wards would be provided for in the community by the closure date. If they were, the closure programme would be evaluated in terms of the smoothness of its implementation and the adequacy of community provision. If they were not, evaluation would centre on any constraints to

implementation as well as the consequences for long-stay patients.

2. To find out what 'community care' in Islington meant to ex-long-stay patients by assessing how the different agencies involved in the closure programme had interpreted this policy, and how it was experienced by ex-patients.
3. To determine how far planned reprovizion had been based on an assessment of patients' needs and to what extent patients had chosen their own placements in Islington.
4. To consider if the nature and attitude of the host community was an important consideration in the implementation of the policy of community care for ex-Friern patients in Islington.

#### THE COLLECTION OF PRIMARY DATA

In order to answer the research questions outlined above 26 hospital or community-based professionals (and one group of professionals) who were employees of the statutory or voluntary agencies with some involvement in Islington's Friern closure programme were interviewed about their general or particular experience of hospital closure and care in the community for ex-long-stay patients using semi-structured interview schedules. Also 20 ex-Friern patients were interviewed using semi-structured interview schedules about their experience of life pre-hospital, life in hospital, moving from the hospital to the community and various aspects of life in the community, including a consideration of the hospital looking-back. The carers/workers/contacts of the 12 ex-long-stay patients who

were part of the Friern closure programme were also interviewed using semi-structured interview schedules.

In addition, two groups which selected patients for residential projects in the community were attended by the researcher as an observer for 15 months. A Users Group, Residents Meeting, and Planning Committee meeting were also attended as an observer and Ward Presentations as a participant observer.

The main problem which arose in the collection of primary data was in gaining access to ex-long-stay patients and securing their agreement to participate in the research. This was a problem also encountered by Jones (1985)<sup>1</sup> and Goldie (1988)<sup>2</sup>. In this case, it can partly be attributed to 'over-researching', since all the subjects of this study were being objectively studied by TAPS. However, it was compounded by the time which elapsed between securing agreement in principle with residential project managers and actually approaching the people living in their projects about the interviews.

Since only two ex-long-stay patients (who were part of Hampstead's closure programme) had been interviewed in the Pilot Study and such a small number (10) of ex-long-stay patients in Islington had agreed to be interviewed, it was decided to increase the number of ex-patients in the study by interviewing eight people attending a Day Centre in Islington who had had some connection with Friern Hospital. These ex-patients were ex-long-stay pre-closure programme or short-stay before or during the implementation of the Friern closure programme. This would allow some comparison to be

made between districts and between different types of ex-patient in Islington. It should be noted that when reference is made to the conclusions drawn from the experiences of the ex-patients interviewed in this Chapter, unless otherwise specified, they refer to all three groups.

The process of approaching ex-long-stay patients was more time-consuming than expected and this, and the fact that the operational date of one project particularly targeted to be part of the research was substantially delayed, meant that there was no longer time to conduct the survey of community attitudes. Thus, community attitudes could only be deduced from the accounts of ex-patients, project workers and progress reports on projects.

The only other problem encountered by the researcher was adhering to the role of observer (rather than participant-observer) when attending meetings of the two groups which selected patients for residential projects in the community.

#### SECONDARY DATA AND 'POLICY' LITERATURE

A review of policy documents, minutes of meetings and other reports compiled by the agencies involved in Islington's Friern closure programme was also undertaken, and local media accounts of events in the closure programme were used as an interpretation of events. These sources of secondary data served to 'embellish the picture' of Friern Hospital closure and community care in Islington.

A literature review on the condition known as schizophrenia was undertaken for two reasons - to educate

the researcher about the various aspects of this illness to enable her to carry out the interviews with ex-patients and interpret their replies, and also to predict the effect of the change in social policy for those presently diagnosed as 'schizophrenic' and those who would suffer from this condition in the future. The researcher noted that there was tentative lay evidence in the transcripts of interviews to support the Environmental Theories of Schizophrenia and age of onset discussed in Chapter 5.

A review of literature on the history of the mental health services in England & Wales was also carried out to place this small-scale study in a wider historical context and to identify recurring themes in the 'history' which may be significant with regard to the policy of hospital closure and providing care in the community. This formed a backdrop for the history of Friern Hospital which was a concrete example of mental health policy in the past 150 years and showed that an act of policy does not always have the immediate desired effect and may even have contradictory effects. It also described the 'home' of the people who were the subjects of this research, which may affect how they experienced life and were perceived in the community. Similarly, the rationale behind the closure decision and the unfolding of the closure programme had implications for all Friern patients during the closure programme and when they finally moved to the community.

### GENERALISING FROM THE FINDINGS

The above shows that this small-scale study does not exist in a vacuum since it is both a 'valid' and 'typical' example of the effect of a national policy. It is concerned with the social structure which generated the meaning to which such importance had been attached in this study - the experience of hospital closure and providing care in the community with particular emphasis on the recipients of the policy.

Thus, there is a fusion of macro and micro levels of analysis in this study in that a qualitative approach has been used to conduct research into one example of a major change in social policy and analysis at the micro level has been taken as 'representative' of analysis at the macro level. In producing a meaningful insight into this particular area of study it is, therefore, possible to cautiously generalise from the conclusions drawn from, and recommendations made as a result of, this small example of a national phenomenon.

### CONCLUSIONS FROM THE POLICY LITERATURE

The majority of people residing in large mental hospitals have been suffering from schizophrenia. Given the policy of closing these hospitals, that there has been no change in the prevalence rate of schizophrenia in the past 150 years (Hare 1967<sup>3</sup>), and that there is still no 'cure' for this condition, there will be a growing number of people suffering from schizophrenia in the community in the future. However, they will still require hospital beds to allow proper diagnosis and treatment in times of acute episodes.



The symptoms of schizophrenia can be both frightening and socially disabling for sufferers. To others, they may be difficult to understand and threatening. As a result of these symptoms and the side-effects of treatment, people suffering from schizophrenia may find it difficult to go unnoticed in the community and may be shunned, ridiculed, provoked or treated cruelly. If this reinforces delusional thinking and feelings of persecution, they may become dangerous and display the behaviour the public fears and as a result come in contact with the police, the courts and prisons, as tabloid newspaper accounts of the crimes of 'schizophrenics' testify.

Adverse media representations of mentally ill people in general and people suffering from schizophrenia in particular are characterised by ignorance and do not recognise that these people may be the victims of both an illness and inadequate care. This serves to reinforce negative attitudes and perpetuate the stigma.

The stigma attached to mental illness is a recurring theme in the history of the mental health services in England & Wales. It has its roots in the early perceptions of madness as unreason and evil and has been manifested in the harsh treatment and neglect of mentally ill people.

The stigma attached to mental illness in general and schizophrenia in particular means that some people or their families may not seek help in the early stages and, in the absence of hospital facilities, the family may not be the appropriate social environment for treatment. Also, some

people may not have families who are able or willing to carry the burden of care.

Another recurring and associated theme in the history of the mental health services is a general fear of mental illness because of its link with the 'unnatural', the idea that it may be incurable, the resultant loss of financial and social status, control over one's own life, and also fear of confinement, harsh treatment and neglect. Since psychiatry was born in the asylum, there is also professional fear of loss of prestige with the move to the shared responsibility for treatment of mental illness in the community.

Inequality in the care and treatment of mentally ill people is another feature of this 'history', whether between rich and poor, urban and rural areas, and geographically close health districts and local authorities.

Mentally ill people have 'historically' occupied a lowly position on the social welfare priority ladder, whether because of the lack of allocation of adequate resources for their care and treatment or because they have not been the subjects of their own history, that is, the welfare of mentally ill people and their relatives has not always been the primary motivating force in changes in legislation. There has been an emphasis on administrative development and legislation has been for the benefit of the sane, a reaction to public concern, a reflection of the power of specific individuals or different professional groups, and dictated by financial concerns which are largely the product of political motives.

The movement to the policy of community care did not constitute what Kuhn (1962)<sup>4</sup> describes as a 'paradigm shift'. This was because many people believed that institutional care was still the answer to the problem of caring for mentally ill people. Many were also sceptical of the claims on which the policy of community care was based, for example, the efficacy of drug treatment, and the projected decrease in the demand for beds, and that it would cost less to provide appropriate care in the community than to maintain and modernise the large mental hospitals. However, just because the primary motivating force for a major change in policy is wrong, for example, to satisfy financial rather than humanitarian aims, it does not mean that the policy is wrong. However, it is unlikely that everyone will put all their efforts (financial, political and professional) into its implementation, which will naturally have a negative effect on outcome, and then rally round to defend it from public criticism.

In the history of the mental health services in England and Wales, the pattern of care so far has been integration (general provisions for social 'misfits'), separation (the asylum system), and integration (community care). However, if mentally ill people continue to be found in the modern-day equivalents of the Workhouses and Gaols in the original period of 'integration', which were ill-equipped to cater for their needs, that is, on the streets, in hostels for the homeless, in prisons, or in suicide statistics, as some people who were against the closure of large hospitals

predicted, public and professional concern may result in community care leading to another period of separation.

This major change in social policy can only be considered to be 'progress' if the recurring and negative themes identified in the history of the mental health services are eradicated.

A climate of fear is clearly detrimental to the implementation and sustaining of a policy of community care. Therefore, attempts must be made to erode the stigma attached to mental illness in general and schizophrenia in particular. This can only be achieved through education. However, if community care is to successfully usurp its predecessor, institutional care, then there should not just be education programmes for communities targeted to receive long-stay patients, but also a national education programme with particular emphasis on GPs.

For long-stay patients and other people with mental health problems to be adequately treated in the community, the community must provide services to fulfil all the functions of the large mental hospital - diagnosis and treatment, protection, satisfaction of basic needs, provision of work and leisure-related activities, and relief for carers.

However it follows that, as people with mental health problems are not a homogeneous group, there must be variety in the types of services available to satisfy their different and ever-changing needs. There must be a range of residential facilities for those who are unable to live in an unsupported environment and hospital beds for those whose

mental condition is such that they require such care. There must also be opportunities for work and to engage in social activities. Assurance is also necessary that people with mental health problems have equality of care within and across different health authorities.

A firm and substantial financial commitment is, therefore, required to provide the wide range of facilities and services in all communities to meet the varied and ever-changing needs of all people with mental health problems and to initiate a public education campaign which will engender tolerance to them. Only then can it be concluded that the major change in social policy has been accompanied by mentally ill people occupying a much higher rung on the social priority ladder.

#### ANSWERS TO THE FOUR RESEARCH QUESTIONS

1. Were all the long-stay patients on the Islington wards provided for in the community by the closure date?

All the long-stay patients on the Islington wards of Friern were provided for in the community by the closure date of the hospital. However, this was in terms of numbers rather than the appropriate location to meet their needs, that is, they were all placed in alternative accommodation but in some cases it was not necessarily the most suitable destination for them but the only place which was left.

#### Financial v. Humanitarian Concerns

Long-stay patients were provided for in the community in terms of numbers rather than the most appropriate locations because NETRHA had given a specific closure date and put

pressure on local planners and providers to empty the hospital as quickly as possible so they could avoid the huge cost of maintaining the hospital and promptly capitalise on the high value of the Friern site.

The primary motivating force in the opening of Colney Hatch Asylum was to reduce the cost of containing mentally ill people in other establishments. Friern patients had consistently occupied a low rung on the social priority ladder as seen in the way successive administrations strove to keep the cost of their care down. Also, during both World Wars when their beds were needed for the war-wounded and staff for the war effort, there was a resultant suspension of opportunities for work and a social life.

According to NETRHA (1982)<sup>5</sup>, Service Provision Indicators were more important than Financial Indicators with regard to the identification of hospitals for closure and they made some admirable statements about the well-being of patients during the closure programme and the advantages of providing care in the community in terms of 'quality of care' for the long-stay patients on the back wards of the hospital.

However, during the closure programme, the negative effect of running down hospital services on the patients still waiting to leave, the movement of patients to effect ward closures and release parcels of land for sale in spite of the increasing demand for admission showed that humanitarian concerns were not the main priority. Also, when NETRHA experienced financial problems in 1991, these humanitarian concerns again took second place to their

financial counterparts as seen in the proposal to close Friern early, forcing Haringey to select the cheapest of three reprovision options, and the termination of the Highbury Parkside in Islington. Thus, the passing of time had not been synonymous with a change in priorities, financial concerns still outweighed humanitarian concerns.

#### **Demand for Admission**

If admission rates, as a measure of need, had been taken as an 'indicator' of the feasibility of closure, Friern may not have been so easily identified as one of the hospitals which should close. In the long history of Friern, the demand for admission had always exceeded the number of beds available and, no more so, than during the closure programme.

Since a significant number of the first leavers, who were reported by TAPS (Dayson 1993<sup>6</sup>, Jones, 1993<sup>7</sup>) to be the less disabled of the total Friern population, had to return to hospital for short periods due to psychiatric and psychological deterioration, it was likely that there would be an increased demand for admission in the future. Indeed, two of the ex-long-stay patients interviewed had had unsuitable first placements and two had had to return to hospital for short stays when their mental state was such that they could not be cared for in the community setting. The-readmission of Friern ex-long-stay patients even after two or three years of living in a project in the community highlighted the need for hospital care for this group in the future.

However, since the Whittington Psychiatric Unit was unable to cope with the demand for largely acute admission

before the closure of Friern, it was unrealistic to expect that it would be able to cater for the needs of the ex-Friern patients in the future. They, like other people with mental health problems may find it difficult to find a 'community' like Friern, which despite all the negative aspects of hospital life, provided for all their basic needs (safety, shelter, food) and care from a variety of specialists on a 24 hour basis when their problems pose a threat to themselves or others, unless they or their families can pay for private 'asylum'.

If, as was predicted, the psychiatric wings of other hospitals in the districts previously served by Friern were also unable to cope with the demand for admission once the hospital finally closed, it was expected that North London would be confronted with a mass of disturbed and disturbing individuals, showing visible signs of neglect, wandering the streets and sleeping rough. This would inevitably make the community less tolerant of people with mental health problems and less inclined to support the policy of community care.

This was a concern of the Report of the Inquiry into the Care and Treatment of Christopher Clunis (1994)<sup>8</sup>, that is, that due to under-funding, a shortage of beds, absence of a wide range of supported housing including 'haven-type' accommodation and supervision registers for special groups of patients, community care may be discredited.



Impediments to the Smooth Implementation of the Closure  
Programme and the Adequacy of Community Provision

**Negative Feelings and Attitudes of Patients**

One impediment to the smooth implementation of the closure programme was the negative feelings of patients about hospital closure which were reflected in negative attitudes to leaving.

Those who had been in hospital for a short time (two years or less) and those who had been in hospital for many years (12+) seemed to be more positive about hospital closure and leaving than the 'medium' long-stay. This may have been because the former were neither so institutionalised nor anxious about returning to the community and the latter were so institutionalised they had become resigned to their fate and, after years of neglect, they had suddenly become the focus of attention. Rather ironically, the shock and feeling of instability caused by a tragedy, the Hospital Fire in 1988, seemed to make those who felt negatively about closure more amenable to leaving.

All the ex-patients who were not part of the closure programme felt negatively about the Friern closure because even though they did not expect to require hospital care in the future, they were concerned about the fate of people who may be as ill as they had been.

**Differences in the Hospital and Community Environments**

It would have been unrealistic to expect patients to make a totally smooth transition to living in the community partly because of the differences between the hospital and community living environments. Friern Hospital was located

in huge grounds in an area which had never been densely populated but within the hospital, patients had lived in very close proximity to each other. Most accommodation in the community, although 'luxurious' compared to Friern, was situated in 'built-up' areas and, therefore, did not have the same external space. Also, in offering personal space in the form of individual bedrooms, it did not have the same internal social proximity.

Further, behaviour which was common-place in the hospital, for example stubbing out cigarettes on the floor, was not acceptable in the community because it ruined carpets and constituted a fire risk. In Friern, patients were 'with their own' and they were not ridiculed for odd behaviour or appearance. The allocation of money to ensure that patients were 'properly dressed' for the community was further evidence that it was anticipated that what had been acceptable in the hospital may not be tolerated in the community. Consequently, it was understandable that some patients found it very difficult to adapt to living in the community.

#### Shortage of Property in Islington

Another impediment to the implementation of community care in Islington was the shortage of property for residential accommodation and other facilities, for example, Community Mental Health Resource Centres. The fact that seven young people were made homeless by a project (Aberdeen Road) for elderly people suffering from dementia from Friern

highlights the scarcity and competition for property in Islington.

If it had not been for the availability of properties owned by the Housing Corporation via Housing Associations and managed firstly by the voluntary organisations and later by the statutory sector, the shortage of property in Islington would have been a serious stumbling block to the implementation of the closure programme.

#### **Staff-related Problems**

The high turnover of nursing staff, swopping between districts, low morale and standards and negative attitudes to new workers, which must ultimately have increased the anxiety and progress of the patients in their care, was another impediment to the smooth implementation of the closure programme. This appears to have occurred because nursing staff were not properly consulted about the hospital closure, were not initially kept well-informed about closure plans and not given an early commitment to alternative employment in Islington.

Another impediment to the smooth implementation of the closure programme were the differences and disagreements within and between the statutory agencies and between the statutory and voluntary sector involved in hospital closure and providing care in the community. Examples of such differences and disagreements were manifested in such issues as whether or not the hospital should close, philosophy on the care and treatment of mentally ill people which was evident in the level of support provided in residential

projects, medication policy, and the selection and preparation of patients.

There was, therefore, evidence to support Smith et al's (1993)<sup>9</sup> acknowledgment that the problems encountered by health and social work professionals involved in collaborative working are a reflection of professional differences in beliefs and behaviour (particularly seen in approaches to risk-taking and assessment of users), and that 'tribal ties' may diminish not so much, in this case, between those in hierarchically similar positions but between those working in the same location - hospital or community.

There was also evidence to support Smith et al's observation that this gulf may be even wider between the statutory and voluntary sector because of the importance attached to 'professional' and 'lay' knowledge. Also, that these differences are not confronted by equals in terms of power since it is the statutory agencies who control resources and can choose the way priorities are set, who is included/excluded, the issues for debate and the language used in debating. In Islington, for example, residential project managers had the final say in selection but the health authority had the power of veto and showed a desire to transfer its authority in the hospital to the community by insisting on additional levels of support in projects. However, in this case, the voluntary organisations did not always allow the transfer of this authority since they were offering projects which were financially attractive to the health authority.

Many of the disagreements and uneasy relationships outlined had implications for the continuity and equality of care of patients in the community (discussed below). They could have been minimised if, for example, there had been specific terms of reference for different groups, the roles and responsibilities of different professionals had been more clearly defined and there had been specific guide-lines on the meaning of community care in Islington. However, in the absence of a clear directive from the Region on this, it is understandable that there was 'confusion' at a District level.

## 2. What did 'community care' in Islington mean to ex-patients?

Just as with psychogeriatrics, community care in Islington for ex-patients (non-psychogeriatrics) meant care in the community, that is they had been provided with residential accommodation in the community.

### Living in the Community

The general feeling about living in the community was positive which was also a finding of TAPS (Anderson et al, 1993<sup>10</sup>) and Goldie (1988)<sup>2</sup>, and familiarity with the area appeared to have a positive effect on adaptation to living there. The majority made good use of places in the community, however, they seemed to have little contact with people in the community. The majority had had little or no contact with neighbours and only one had had serious problems with neighbours.

The overall response of ex-long-stay patients to hospital staff was positive. However, the feelings about

the hospital, looking back, seemed to confirm the positive attitude to living in the community in that they were generally negative even though half had visited the hospital since leaving. This ambiguity was likely to be a reflection of the long time spent in hospital compared with the short time in the community - they no longer wanted to live in the hospital but liked to see familiar faces and surroundings.

The ex-patients who were not part of the closure programme had positive memories about the hospital but not about the hospital staff. This appeared to be because the longer they had been in the community, the greater the time available to counteract the effects of institutionalisation and view the hospital more objectively (a place of safety when ill), and the less likelihood of returning to hospital and coming into contact with staff (which was not an expectation of the majority of closure programme patients).

The majority of ex-patients had made good progress in the community. This showed that long-stay stay patients could have been discharged before if they had been the subject of intensive rehabilitation work and there had been somewhere to discharge them to. The fact that many were surprised that the researcher wanted to speak to them about their experiences and that some were very quiet and withdrawn when they first moved in shows the effect of the institutional environment and that they had largely been forgotten in hospital. Therefore, the decision to close Friern had ultimately been to the benefit of long-stay patients because, otherwise, many would have ended their days in hospital.

Although the majority of ex-long-stay patients had made good progress in the community, old age and physical frailty, vulnerability and violent behaviour was an impediment to some moving on to more independent living. This meant there would not be many vacancies in the projects in the community in the near future. Therefore, there would be few places to offer to ex-short-stay and 'revolving-door' patients and people who would suffer from mental health problems in the future and need to be cared for in a supported environment once Friern finally closed. This is further evidence of the demand for hospital beds discussed above.

#### Lack of Integration in the Community

At the time of the interviews, there was little evidence to suggest that ex-patients had become integrated in the community. The majority had minimal contact with people in the community and they lacked opportunities to engage in paid work and organised social activities. Also, financial hardship made it difficult to take part in 'mainstream' leisure pursuits.

Opportunities to engage in paid work and in recreational and social activities had been an enduring and positive feature of hospital life, and it had been the sheer size of the Friern population and the facilities available on the hospital site which made it practically and financially possible to provide these. It was certainly not possible to organise social events for small groups in the community at such a low cost and as a result of financial

difficulties, it is understandable that providing money so that ex-Friern patients could have 'fun' in the community was not a high priority for Health Authorities.

The things people mentioned as liking about the hospital could broadly be described as work and social activities. However, the people interviewed did not enjoy the same opportunities to engage in paid work, and/or the desired forms of work, or social activities in the community as they had had in the hospital. Further evidence of this was seen in the return of discharged patients to Friern to attend the South Workshop and to visit friends which was an impediment to them both settling and becoming integrated into the community. Further, there was no conventional distinction between work and leisure time which coupled with lack of contact with people in the community meant that many spent long periods in the solitary, unproductive but inexpensive pursuit of watching TV which was also a feature of hospital life. In the absence of the opportunities to engage in paid work and to participate in organised social events, people may have 'lost out' by the move to the community and there had been no 'continuity' in their care.

It was due to staff cuts in LBI's Centres which had effectively negated the new posts created to cater for people coming from Friern, and the delay in some plans and the cancellation of others due to lack of revenue, that provisions for day care and employment for people leaving Friern were well behind and insufficient compared to those made for 'accommodating' them in the community.



If integration in the community is an aim of community care then the opportunities to engage in paid work, other day-time activities and social events should not be lagging behind the provision of residential accommodation. This is because work provides the motivation to adhere to a structured day which can increase self-esteem and engender independence and also provides relief from financial hardship which precludes participation in social activities which are necessary to practice social skills and broaden social networks.

In the absence of financial support from family, paid work, and savings, the majority were in financial hardship especially people who smoked since this was the greatest consumer of scant resources and a product of hospital life. They were more disadvantaged than other people living on Benefits because they had little or no material possessions to sell in times of need and lack of the self-confidence and skills to find and undertake casual 'cash-in-hand' work. Although they received slightly more spending money in the community than they had in Friern, it did not 'go as far'. Financial hardship made it difficult to participate in mainstream social activities, to purchase 'entertainment' and they had no alternative 'social life' because they were not part of an established social network.

The majority would, therefore, have benefited from being part of a Befriending Scheme, especially when they first left hospital and if they were or became physically frail which curtailed involvement in the wider community. However, this Scheme never came to fruition. The majority

would also have benefited from attending meetings of the Islington Mental Health Forum - to talk about their experiences and problems, expand their social network, and increase self-confidence by exorcising the stigma attached to mental illness. However, it appeared that people either did not know about this Forum or considered it to be 'stigmatising'.

The problem of inadequate day care facilities, lack of opportunities for work and the resultant negative effect on finances and social activities was also identified by Goldie (1988)<sup>2</sup>, Birch (1983)<sup>11</sup> (1983), Kay & Legg (1986)<sup>12</sup>, McLean (1987)<sup>13</sup> and Rayner & Quarry (1987)<sup>14</sup>.

#### Inequality of Care in the Community

Diversity in the destination of ex-patients in the community was found by Jones (1985)<sup>1</sup> and Goldie (1988)<sup>2</sup>. However, in the absence of specific directives from NETRHA to the District Health Authorities on what 'community care' should entail it is understandable that not only was there diversity in the destination of ex-Friern patients in the community but there was also no guarantee of 'equality of care' within and between districts.

Due to the different philosophies of the managing agents reflected in, for example, the type of accommodation being provided, level of support, and policy on medication, and also the difference in perspective between the statutory professionals involved in moving them from the hospital to the community, and supporting them there, and the lack of clearly defined areas of responsibility, ex-long-stay

patients had very different experiences of moving to the community and did not have equality in care in the Islington.

Not only was there was inequality in care between projects but also within one particular project - Adult Care. This was because the care provided depended very much on the integrity of the carers to provide what was expected. There was concern that placements were being run like small businesses and that ex-patients found it difficult to complain about the care received at Reviews in the presence of carers. Living in the Friern area with ex-nurses and having a social worker in the hospital Social Work Team meant there were additional difficulties for some people in Adult Care in terms of day care places, building and maintaining community links and breaking ties with the hospital. Also, those who were not made 'part of the family' were more disadvantaged with regard to social activities than those in Group Homes since project workers did try to organise some events for residents.

The differences between the Hamsptead and Islington ex-long-stay patients is further evidence of lack of equality in care for patients from the same hospital. For example, the former appeared to have less contact with professionals in the community and a more 'brusque' method of moving them from the hospital to a project in the community than the latter.

The differences between the Islington patients who had been part of the closure programme and those who had not was further evidence of the inequality in care in the community.

The majority of the former had had much less contact with professionals and had to rely on their families and friends to help them with problems although since many of their friends were also mentally ill, they were often unable to help. There was, therefore, evidence of a need for the one-to-one 'talking treatments' identified in the MIND (1993)<sup>15</sup> survey of service users for these ex-patients, to avoid relapse due to the stress of coping with problems which may result in the need for hospital admission.

3. How far had planned reprovizion been based on an assessment of patient's needs and to what extent had patients chosen their own placements in Islington?

The patients in Colney Hatch Asylum were forced to remain in hospital and the modern-day Friern patients were forced to comply with the closure programme and eventually leave, as a result of the closure decision about which they had not been consulted. Neither had any 'choice' so the passing of time with regard to taking patients' views into consideration had not been synonymous with progress.

Planned reprovizion in Islington had not been based on an assessment of patients needs since the first five residential projects in Islington had been decided upon before the assessment of patients had been completed. Under-occupation of projects was further evidence that projects had not been designed to fit the needs of patients. Also some of the final patients to leave Friern ended up in projects which were not really suitable for them, for example, a home for older mentally ill people who were also

beginning to suffer from dementia or people classified as 'special needs', because there was nowhere else for them to go.

Patients had not chosen their own placements, rather they were selected for their suitability or ability to adapt to the projects in terms of, for example, the level of support offered, medication policy and the emphasis of the living environment - independent or communal. Ward presentations were largely 'recruitment exercises' in that patients were never presented with a range of projects (which was also a finding of the MIND survey) and asked to indicate their preference and projects which they may have been attracted to were not modified to satisfy their needs, for example, by providing disability access or 24 hour nursing care.

Patients were not represented at Project Group meetings and little priority was given to their opinions about moving to a particular project, for example taking out Guardianship Orders for people whose families were resistant to the idea of them moving to a project which they wanted to move to and were considered suitable for, or desire for a specific type of project, for example, women only. The only real choice about their final destination in the community that some patients had until nearer the end of the closure programme was refusing to cooperate with the preparatory work for a particular project, including moving to the project-designated ward, or refusing to leave the hospital.

If Friern had had a Patients Council, patients may have been able to voice their opinions about the closure during

the consultation process and also have a platform for airing their views about their destination in the community.

Not only were residential projects not based on an assessment of patients needs, but there was very little attempt to assess whether projects patients had moved to were still catering for their needs. Islington Health Authority were generally 'weak' on formal monitoring arrangements as seen in, for example, the disappearance of an ex-patient from Clerkenwell and the eviction of another from the MIND project. In the absence of a Case Coordination System (which was not implemented until the third last year of the closure programme), these people had 'slipped through the net'.

4. Was the nature and attitude of the host community an important consideration in the implementation of the policy of community care for ex-Friern patients in Islington?

The first inmates of Colney Hatch were out of the sight and mind of the public because the surrounding area was uninhabited. There was a tolerant population around Friern because all the residential areas in the vicinity had grown up around the Hospital and the area had never been densely populated when compared to the Inner London boroughs which were to play 'host' to Friern patients.

Some people living in these areas may have inherited an image of Friern patients as being paupers, incurable, unwanted, and dangerous people who were 'banished' to Colney Hatch. Therefore, long-stay patients may be stigmatised because of the history of the hospital. They were also

likely to be 'noticeable' in the community because of the symptoms of schizophrenia, social behaviour problems and disabilities caused by long-term institutionalisation and the side-effects of treatment. If intolerance, lack of understanding, fear, and hostility are the attitudes of people in the host community to those bearing the 'ex-Friern' label, not only will their settlement and integration be impeded, but they may fulfil people in the community's worst expectations of a closure programme about which they were not consulted.

Therefore, the nature and attitude of the host community appeared to be an important consideration in the implementation of the closure programme but due to the shortage of property in Islington (already discussed), providers did not have the luxury of establishing this before siting projects in particular areas. Even when there was evidence to suggest that people in a particular area had a negative attitude, the need for accommodation was the overriding consideration as seen in the opening of an Intensive Rehabilitation Unit in an area whose residents had objected when they had been consulted about setting-up a group home providing care in the community to elderly people suffering from dementia in Aberdeen Road.

There was some evidence of Dear & Taylor's (1982)<sup>16</sup> 'accepting' communities around the Peter Bedford Trust and MIND residential projects in the north of Islington which was where the majority of accommodation and other facilities, including the Whittington Psychiatric Wing,

were sited. However, it was difficult to clearly identify 'rejecting' communities.

Nevertheless, the opposition of GPs to the Psychiatric Rehabilitation Association's residential project in the south of the borough seemed particularly serious in that if GPs will not accept long-stay patients moving into their locality then other people in the community can hardly be expected to show a positive attitude.

It was further noted that the granting of planning permission for a residential project, as in the case of the afore-mentioned, is no guarantee that local opposition has been quashed and that initial goodwill of a community to a project (Clerkenwell) can be maintained when confronted by a long delay in the operational date and a change in the characteristics of the residents.

The majority of Aberdeen Road residents viewed mentally ill people in a negative and stereotypical way and clearly articulated their objections which were characterised by ignorance of mental illness and fear of mentally ill people. Whether these objections were aimed directly and with hostility at the ex-patients who would be living there or disguised by concerns about their welfare and how 'obvious' the project would be out of anxiety about falling property values, they certainly did not apply to the proposed residents of this project, its organisation and external features.

It should be noted, however, that although there was some indication of ridicule, rejection and hostility by long-established residents in the community, in written



reports on the progress of ex-long-stay patients in residential projects and also in the accounts of workers/carers/contacts, ex-patients in Islington did not perceive themselves to have been either accepted or rejected by the community. This may be because the attitude of people in the community is of low priority to them when compared to adapting to living in the community and coping with mental health problems.

#### GENERAL RECOMMENDATIONS FOR HOSPITAL CLOSURE PROGRAMMES

The decision on whether or not a hospital should close should be based on an assessment of long-stay patients, current admission rates to the hospital and other hospitals in the area, financial and other resources available to provide care in the community, and the views of staff working in the hospital and the community, long-stay patients and the people in the community in which they are to be relocated.

If the decision is made to close the hospital, administrative, management and primary care hospital and community-based staff from the statutory and voluntary sector in the area served by the hospital, and representatives from User and Community Groups should all be involved at the planning stage of hospital closure and providing care in the community.

The assessment of patients needs should dictate the types of residential projects, work-related and social activities to be provided in the community and the latter should not be lagging behind the former. Indeed, the

provision of work-related and social activities before the completion of residential projects may provide the incentive for initial visits to the community especially for those long-stay patients who feel negatively about closure and leaving.

Wherever possible, patients should be able to indicate their preference for particular projects in the 'selection box' and enabled to realise this preference. The movement of patients to effect ward closures should be kept to a minimum and the closure of wards and other hospital services should not occur until there is evidence that the demand for admission is being met elsewhere.

In order to minimise disagreements due to 'natural' differences within and between professionals and agencies involved in the closure programme and providing care in the community and to ensure 'equality' in the care of ex-patients in the community, there should be specific directives at a regional and local level on what community care means.

A mixture of hospital and community-based staff should be involved in preparing patients for the move and supporting them in residential projects in the community. The former should be given the opportunity and adequate time for retraining for community posts and both should be employed on fixed term posts to guarantee initial 'continuity' in care.

Areas of operation and responsibility for staff involved in the closure programme and providing care in the community should be clearly defined and the appointment of

workers to promote activities to support ex-patients in the community and encourage integration in the community should not be behind those concerned with the hospital evacuation.

As much attention should be given to establishing both the lower cost, more procedural and peripheral, yet no less vital aspects of community care, for example, Terms of Reference of specific Groups, Case Coordination and Progress Monitoring Systems, Befriending Scheme than the higher cost structural aspects such as residential projects. The computerisation of patient assessments and the appointment of an administrator to oversee both the input of data on, for example preparatory work, and the networking of this to relevant professionals would considerably cut down on their workload by minimising administration and the repetition of tasks, and also be more efficient in that up-to-date information on the progress of patients would be available to all concerned.

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